

Reg. No.

96 25501

1. Decedent's Name (First, Middle, Last) **LESLIE SHOWACRE Jr.** 2. Date of Death Month **AUGUST** Day **27** Year **1996** 3. Time of Death **2100**

4a. Facility Name (If not institution, give street and number) **Johns Hopkins Bayview Medical Cen.** 4b. City, Town, or Location of Death **Baltimore** 4c. County of Death **N/A**

5. Social Security Number **215-28-2337** 6. Sex ☒ M ☐ F 7. Age (In yrs. last birthday) **65** Yrs. 8. Date of Birth **Feb. Jan 16, 1931** 9. Birthplace (State or Foreign Country) **Maryland**

10a. State **Md.** 10b. County **Baltimore** 10c. City, Town or Location **Dundalk** 10d. Inade City Limits ☐ Yes ☒ No

10e. Street and Number **7414 St. Patricia Ct.** 10f. Zip Code **21222** 10g. Citizen of What Country? **USA**

11. Marital Status ☐ Never Married ☒ Married ☐ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: **White**

15. Decedent's Education (Specify only highest grade completed) **12 yrs.** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Fireman** 16b. Kind of Business/Industry **Balto. City**

17. Father's Name (First, Middle, Last) **Leslie Showacre Sr.** 18. Mother's Name (First, Middle, Maiden Surname) **Virginia T. Kraft**

19a. Informant's Name/Relationship (Type, Print) **Charlotte Showacre** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **7414 St. Patricia Ct. Dundalk Md. 21222**

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify): 20b. Place of Disposition (Name of cemetery, crematory or other place) **Gardens Of Faith** Date **8-30** 20c. Location - City or Town, State **Rosedale**

21. Signature of Funeral Service Licensee **[Signature]** 22. Name and Address of Facility **Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222**

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Lung Cancer with metastasis** Due to (or as a consequence of): **few months**

23b. Did tobacco use contribute to the cause of death? ☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☐ No

25. Was case referred to medical examiner? ☐ Yes ☒ No 26. Place of Death (Check only one) Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury **M** 28c. Injury at Work? ☐ Yes ☒ No 28d. Describe how injury occurred

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier **[Signature] Med. Specialist** 29c. License number **D40356** 29d. Date signed (Month, Day, Year) **AUGUST 27, 1996**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **W. NAVARRO 100 N. Broadway, Baltimore MD. 21231**

31. Date filed (Month, Day, Year) **AUG 28 1996** 32. Registrar's Signature **[Signature]**





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ENID MICHELLE SCOTT</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>28</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>11:00 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>545-04-5657</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>47</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>Oct. 17, 1948</b>		8. BIRTHPLACE (State or Foreign Country) <b>WALES</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>4687 Homer Ave, Suitland</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Suitland, Md 20746</b>		9c. COUNTY OF DEATH <b>PRINCE GEORGE'S</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>P.G. County</b>		10c. CITY, TOWN OR LOCATION <b>Suitland</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>4687 Homer Avenue</b>				10f. ZIP CODE <b>20746</b>		10g. CITIZEN OF WHAT COUNTRY? <b>unknown</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <b>unknown</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>unknown</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (9-12)</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Nurse</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Medical</b>			
17. FATHER'S NAME (First, Middle, Last) <b>unknown</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>unknown</b>			
19a. INFORMANT'S NAME (Type/Print) <b>unknown</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>unknown</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>State rem.</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Joseph B. van Sant</b>				22. NAME AND ADDRESS OF FACILITY <b>State Anatomy Board-655 W. Baltimore Street Baltimore, Maryland 21201-1559</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. CARDIAC ARRHYTHMIA</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <b>seconds</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hyperkalemia</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED			
				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>				29c. LICENSE NUMBER <b>D25925</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAY 29, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>J. BERGER MD #205, 7720 WISCONSIN AVE, Bethesda, Md 20814</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 28 1996</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25503

TEM#1 g738 8/28/96ag perFH

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HENRIETTA ~~STOCKES~~ STOCKS

2. Date of Death

Month Day Year  
AUGUST 20, 1996

3. Time of Death

8 P.M.

4a. Facility Name (If not institution, give street and number)

5 WALDEN LAUREL CT.

4b. City, Town, or Location of Death

BALTIMORE, CITY

4c. County of Death

BALTIMORE

5. Social Security Number

243-03-3890

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
4/10/12

9. Birthplace (State or Foreign Country)

NORTH CAROLINA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE, CITY

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

5 WALDEN LAUREL COURT

10f. Zip Code

21207

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Navar Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

PACKING COMPANY

16b. Kind of Business/Industry

LORD MOTT

17. Father's Name (First, Middle, Last)

HAYWOOD STOCKS

18. Mother's Name (First, Middle, Maiden Surname)

LIDDIE STOCKS

19a. Informant's Name/Relationship (Type, Print)

GERALDINE CHAPMAN (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5 WALDEN LAUREL COURT BALTO., MARYLAND 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WOODLAWN CEMETERY 8/28/96

Data

20c. Location - City or Town, State

WOODLAWN, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ESTEP BROTHERS FUNERAL SER, P.A.  
1300 EUTAW PLACE, BALTIMORE, MARYLAND 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Possible Acute MI

1-2 Days

Due to (or as a consequence of):

b. Unknown Arteriosclerosis (Hypertension)

Due to (or as a consequence of):

c. 1/2 1st stroke

Due to (or as a consequence of):

3-4 yr.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

D14221

8-21-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

T. A. K... 223 E. Blvd BALTO 21211

31. Date filed (Month, Day, Year)

AUG 28 1996

32. Registrar's Signature

J. Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

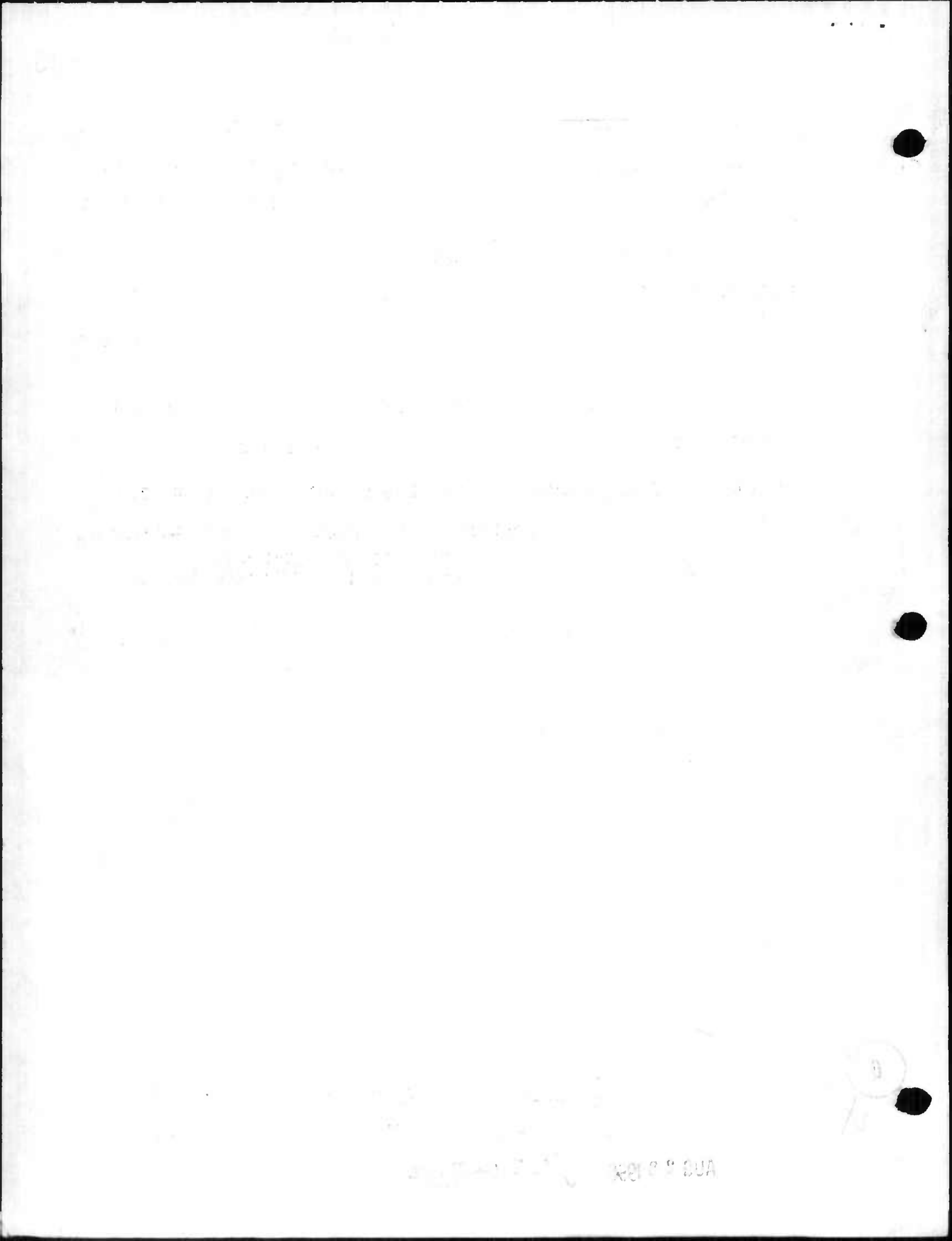
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

This is a Hospital or Attending Physician. The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and sequentially filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25504

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>EMIL JOHN SKYTA</b>				2. Date of Death Month <b>AUGUST</b> Day <b>26</b> Year <b>1996</b>		3. Time of Death <b>1:15 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>MANOR CARE RUXTON</b>				4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>142 05 2195</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>85</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>OCT. 19, 1910</b>	
	9. Birthplace (State or Foreign Country) <b>NEW JERSEY</b>							
To Be Completed by Funeral Director	Usual Residence of Decedent							
	10a. State <b>MARYLAND</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>TOWSON</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>8415 BELLONA LANE</b>				10f. Zip Code <b>21204</b>		10g. Citizen of What Country? <b>UNITED STATES</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>ENGINEER</b>		16b. Kind of Business/Industry <b>PLASTIC MANUFACTURING COMPANY</b>			
	17. Father's Name (First, Middle, Last) <b>ANDREW SKYTA</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>SUSAN HERBANIS</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>RONALD SKYTA / SON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8415 BELLONA LANE, TOWSON, MD 21204</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GREEN MOUNT CREMATORY</b>		Date <b>8/27/96</b>		20c. Location - City or Town, State <b>BALTIMORE, MD</b>	
	21. Signature of Funeral Service Licensee <i>Stephen D. Lohrmann</i>				22. Name and Address of Facility <b>CAFA STEPHEN D. LOHRMANN P.A. 8717 GREEN PASTURES DR., BALTIMORE, MD 21286</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) <b>a. CARCINOMA of COLON</b> Due to (or as a consequence of):				Approximate interval between Onset and Death <b>Months</b>			
	Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b.</b> Due to (or as a consequence of):							
	<b>c.</b> Due to (or as a consequence of):							
	<b>d.</b> Due to (or as a consequence of):							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>AH Ghiladi</i>				29c. License number <b>D-12849</b>		29d. Date signed (Month, Day, Year) <b>8-27-96</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>AH GHILADI, M.D. 7600 OSLER Dr. TOWSON, MD 21204</b>								
State Registrar	31. Date filed (Month, Day, Year) <b>AUG 28 1996</b>				32. Registrar's Signature <i>Nelson-Rendell</i>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25505

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ROSS TRACEY

2. Date of Death  
Month Day Year  
August 26 19963. Time of Death  
7:20 pm

4a. Facility Name (If not institution, give street and number)

Gilechrist Hospice Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

City

Funeral  
Director

5. Social Security Number

227-20-0899

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 26, 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

City

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

3719 Elkader Rd.

10f. Zip Code

21218

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Collage (1-4or 5+)

8

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sales

16b. Kind of Business/Industry

Bowman Distributors

17. Father's Name (First, Middle, Last)

Joseph D. Tracey

18. Mother's Name (First, Middle, Maiden Sumame)

Grace Gent

19a. Informant's Name/Relationship (Type, Print)

Debra Tracey - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3719 Elkader Rd. Baltimore, Md. 21218

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Veterans Mem. Gardens Aug. 29, 1996 Hampton, Virginia

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

J. Barth Elliott

22. Name and Address of Facility

Eckhardt Funeral Chapel  
11605 Reisterstown Rd. Owings Mills, Md. 21117

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. metastatic colon cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

Congestive heart Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

N/A

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

W. A. Riley, M.D.

29c. License number

D25205

29d. Date signed (Month, Day, Year)

August 27, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. A. Riley, M.D. 6701 N. Charles Street. Balto, MD. 21204

31. Date filed (Month, Day, Year)

AUG 28 1996

32. Registrar's Signature

Wilson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

1944 - 1945

1946 - 1947

1948 - 1949

1950 - 1951

1952 - 1953

1954 - 1955

1956 - 1957

1958

1959



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25506

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT CALVIN WILSON

2. Date of Death

Month Day Year  
AUGUST 22, 1996

3. Time of Death

2045

4a. Facility Name (If not institution, give street and number)

SACRED HEART HOSPITAL

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegheny

Funeral  
Director

5. Social Security Number

220-07-7028

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 28, 1921

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Allegheny

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

115 Armstrong Street

10f. Zip Code

21532

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Date:  
to Aug. 5, 1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Florist and Machinist

16b. Kind of Business/Industry

Bethlehem Steel

17. Father's Name (First, Middle, Last)

Herman Calvin Wilson

18. Mother's Name (First, Middle, Maiden Surname)

Mae Olive Thomas

19a. Informant's Name/Relationship (Type, Print)

Mary T. Wilson/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

115 Armstrong Street-Frostburg, Maryland 21532

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board-655 W. Baltimore Street  
Baltimore, Maryland 21201-1559

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

End Stage HEARTIC FAILURE

Due to (or as a consequence of):

Severe Cirrhosis

Due to (or as a consequence of):

Unknown

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 mos

2 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Prostate Carcinoma

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D22181

29d. Date signed (Month, Day, Year)

AUGUST 23, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GARY WAGONER, M.D. 925 BISHOP WALSH ROAD CUMBERLAND MD. 21502

State  
Registrar

31. Date filed (Month, Day, Year)

AUG 28 1996

32. Registrar's Signature

Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1945

1. The first part of the report deals with the general situation of the country and the progress of the work during the year.

2. The second part deals with the results of the work done during the year.

3. The third part deals with the conclusions drawn from the work done during the year.

4. The fourth part deals with the recommendations made for the future work.

5. The fifth part deals with the summary of the work done during the year.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25507

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Levern Jerome Walker

2. Date of Death

August 22, 1996

3. Time of Death

4:48 Am

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

219-62-6173

6. Sex

M 2 F

7. Age (In yrs. last birthday)

38

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

5/3/1958

9. Birthplace (State or Foreign Country)

FLORIDA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

1002 NORTH AVENUE

10f. Zip Code

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CLERK

16b. Kind of Business/Industry

W. Bell

17. Father's Name (First, Middle, Last)

REV. LAWRENCE WALKER

18. Mother's Name (First, Middle, Maiden Surname)

IDA WALKER

19a. Informant's Name/Relationship (Type, Print)

IDA WALKER (MOTHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

128 SOUTH CAREY STREET BALTIMORE, MARYLAND 21223

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WESTERN STAR CEMETERY 8/28/96

Date

20c. Location - City or Town, State

CATONSVILLE, MARYLAND

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

ESTEP BROTHERS FUNERAL HOME PA.

1300 EUTAW PLACE BALTIMORE, MARYLAND 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Probable Sepsis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 hrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cryptococcal meningitis.

Due to (or as a consequence of):

4 weeks

c. End Stage AIDS.

Due to (or as a consequence of):

3 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24e. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending investigation  
2 Accident 6 Could not be determined  
3 Suicide  
4 Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

AT 2438946

29d. Date signed (Month, Day, Year)

August 22, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Wendel Belizaire DO

Union Memorial Hospital.

31. Date filed (Month, Day, Year)

AUG 28 1996

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1000 - 4/2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25508

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Anne Waas				2. Date of Death Month Day Year August 24, 1996				3. Time of Death 9PM	
	4a. Facility Name (If not institution, give street and number) Mariner Health Care of Greater Laurel				4b. City, Town, or Location of Death Laurel				4c. County of Death Prince George	
Funeral Director	5. Social Security Number 132-03-6592		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) March 13, 1918		9. Birthplace (State or Foreign Country) New York	
	Usual Residence of Decedent				10e. State MD		10b. County Prince George		10c. City, Town or Location Laurel	
To Be Completed by Funeral Director		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 14200 Laurel Park Drive		10f. Zip Code 20707		10g. Citizen of What Country? USA		
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home				
		17. Father's Name (First, Middle, Last) Bernard Weintraub		18. Mother's Name (First, Middle, Maiden Surname) Molly Greenblatt						
		19e. Informant's Name/Relationship (Type, Print) George L. Waas/Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3797 Sally Lane, Tallahassee, Florida 32312-1018						
		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore-Washington Cr.		20c. Date 8/26/96		20d. Location - City or Town, State Laurel, Maryland		
		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, MD 20707						
		23a. Part I. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Bronchitis Due to (or as a consequence of): b. Cerabrovensus Accident Due to (or as a consequence of): c. Cererbra-Accident Due to (or as a consequence of): d. Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. Part II. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Diabetes Accident		23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred
		29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D-25867		29d. Date signed (Month, Day, Year) 8/26/96		
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard W. Smith M.D. 10802 Hickory Ridge Rd Columbia MD		31. Date filed (Month, Day, Year) Aug 28 1996		32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25509

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MICHAEL

WISNIEWSKI

2. Date of Death

Month

Day

Year

AUGUST 24, 1996

3. Time of Death

10<sup>05</sup> AM

4a. Facility Name (If not institution, give street and number)

Mercy Hospital Hospice

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

215-64-7829

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

41

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

9-20-54

9. Birthplace (State or Foreign Country)

MO

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

216 S. Olcham St.

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (13-16)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Telecommun. Technician

16b. Kind of Business/Industry

Communications

17. Father's Name (First, Middle, Last)

Chester Wisniewski

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Dombrowski

19a. Informant's Name/Relationship (Type, Print)

Richard Wisniewski/brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O.Box 99, West Friendship, Md. 21794

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Holy Rosary

Date

8-27-96

20c. Location - City or Town, State

Oundalk, MD

21. Signature of Funeral Service Licensee

Dennis S. Kelly

22. Name and Address of Facility

Cvach/Rosedale Funeral Home  
1211 Chesaco Ave. Baltimore, MD 21237

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC COLON CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

~ 8 mos

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. [Signature]

29c. License number

D40480

29d. Date signed (Month, Day, Year)

August 24, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

BERNARDO J. FERRO, MD

5810 BELAIR RD  
BALTO., MD 21206

31. Date filed (Month, Day, Year)

AUG 28 1996

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25510

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WALTER WILLIAMS</b>				2. Date of Death Month <b>August</b> Day <b>04</b> Year <b>1996</b>		3. Time of Death <b>0145AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Allegis of Southern MD 9211 Stuart Lane</b>				4b. City, Town, or Location of Death <b>CLINTON</b>		4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>577-16-3683</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>80</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 24, 1916</b>	
	9. Birthplace (State or Foreign Country) <b>Washington D.C.</b>		10a. State <b>MD</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Washington District of Columbia</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>3298 FT Lincoln Dr N.E.</b>		10f. Zip Code <b>20018</b>		10g. Citizen of What Country? <b>District of Columbia</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unknown</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Construction Worker</b>		16b. Kind of Business/Industry <b>Various</b>		17. Father's Name (First, Middle, Last) <b>Charles Williams</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>unknown</b>		19a. Informant's Name/Relationship (Type, Print) <b>Deborah Nelson/Friend</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>15518 Main Boulevard-Accokey, Maryland 20607</b>		20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>State rem.</b>		
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>in</b>		20c. Location - City or Town, State <b>State rem.</b>		21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Dir.</b>		22. Name and Address of Facility <b>State Anatomy Board-655 W. Baltimore Street Baltimore, Maryland 21201-1559</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>CA of lung</b> Due to (or as a consequence of): <b>ICDDH</b> Due to (or as a consequence of): <b>CHF</b> Due to (or as a consequence of): <b>Dementia</b>		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Philip H. Calcano</b>		
29c. License number <b>D41540</b>		29d. Date signed (Month, Day, Year) <b>21 Aug 96</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Philip Calcano, 9211 Stuart Lane Clinton, MD</b>		31. Date filed (Month, Day, Year) <b>AUG 28 1996</b>		
32. Registrar's Signature <b>Julie Harrison-Randall</b>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

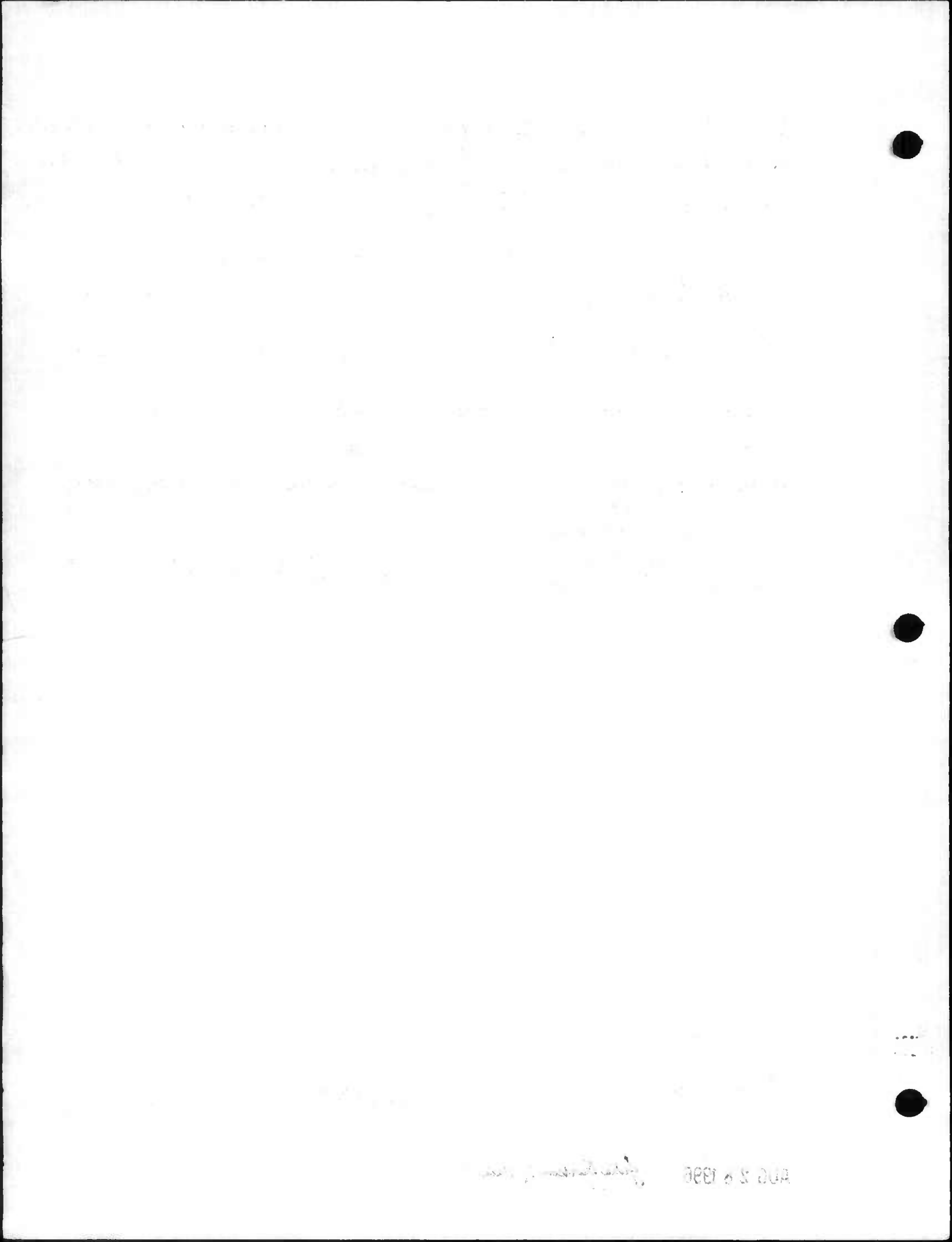
Physician  
/Medical  
Examiner

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Handwritten signature or initials.

0001 6 5 00A

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 25511

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LINDA WRIGHT				2. Date of Death Month Day Year AUGUST 24 1996				3. Time of Death 6:24 pm													
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY				4c. County of Death N/A													
Funeral Director	5. Social Security Number 378 28 8703		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 65 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.													
	Usual Residence of Decedent				6. Date of Birth (Month, Day, Year) March 11, 1931		9. Birthplace (State or Foreign Country) Michigan															
To Be Completed by Funeral Director	10a. State Virginia		10b. County Fairfax		10c. City, Town or Location Fairfax Station				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No													
	10e. Street and Number 10713 Shadowglen Trail				10f. Zip Code 22039		10g. Citizen of What Country? United States															
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White													
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Computer Operator				16b. Kind of Business/Industry Federal Government													
	17. Father's Name (First, Middle, Last) Abraham Koury				18. Mother's Name (First, Middle, Maiden Surname) Radah Kambour																	
	19a. Informant's Name/Relationship (Type, Print) Lida Churchville				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19Q Ridge Rd., Greenbelt, MD 20770																	
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematory		Date 8/28/96		20c. Location - City or Town, State Baltimore, MD															
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286																	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																					
	<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td>Pulmonary embolism</td> <td>Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b.</td> <td>Abdominal aortic aneurysm repair</td> <td>1 hour</td> </tr> <tr> <td>c.</td> <td>Arterio thoracoabdominal dissection of thoraco-abdo</td> <td>10 days</td> </tr> <tr> <td>d.</td> <td>Marfan's syndrome</td> <td>years</td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Pulmonary embolism	Approximate Interval Between Onset and Death	b.	Abdominal aortic aneurysm repair	1 hour	c.	Arterio thoracoabdominal dissection of thoraco-abdo	10 days	d.	Marfan's syndrome
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Pulmonary embolism	Approximate Interval Between Onset and Death																			
	b.	Abdominal aortic aneurysm repair	1 hour																			
	c.	Arterio thoracoabdominal dissection of thoraco-abdo	10 days																			
	d.	Marfan's syndrome	years																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Meningitis & cerebritis.																						
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																						
24a. Was an autopsy performed? Yes 2 <input type="checkbox"/> No																						
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																						
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined																						
28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)																						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																						
29b. Signature and title of certifier Janni C. Bean, M.D.																						
29c. License number J7303																						
29d. Date signed (Month, Day, Year) 8/25/96																						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GARY BELL, DEPT. OF SURGERY, JOHNS HOPKINS HOSPITAL, 600 N. WOLFEST., BALTIMORE, MD 21287																						
31. Date filed (Month, Day, Year) AUG 28 1996																						
32. Registrar's Signature John R. Riddle																						

Baltimore, Maryland 21215-0020

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Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



96 25512

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Charles Bernard Witter</u>				2. DATE OF DEATH MONTH <u>8</u> DAY <u>27</u> YEAR <u>96</u>		3. TIME OF DEATH <u>12:37 P M</u>	
4. SOCIAL SECURITY NUMBER <u>219-01-0160</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>76</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>Aug. 23, 1920</u>	
8. BIRTHPLACE (State or Foreign Country) <u>Pennsylvania</u>				9a. FACILITY NAME (If not institution, give street and number) <u>LongView Nursing Home</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Manchester</u>	
9c. COUNTY OF DEATH <u>Carroll</u>				10a. STATE <u>Maryland</u>		10b. COUNTY <u>Carroll</u>	
10c. CITY, TOWN OR LOCATION <u>Manchester</u>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <u>3105 High St.</u>	
10f. ZIP CODE <u>21102</u>				10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <u>WW II</u>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 8+) <u>2</u>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Barber</u>				16b. KIND OF BUSINESS/INDUSTRY <u>Self Employed</u>			
17. FATHER'S NAME (First, Middle, Last) <u>Guy Diehl Witter</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Frances Motter</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Sharon Miller</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3041 Park Ave. Manchester, Md. 21102</u>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>New Lutheran Cem. Aug. 30, 1996 Manchester, Md.</u>			
20c. LOCATION — City or Town, State				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>J. Galt Eckhardt</u>			
22. NAME AND ADDRESS OF FACILITY <u>Eckhardt Funeral Chapel</u> <u>3296 Charmil Dr. Manchester, Md. 21102</u>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>End Stage Renal Disease</u>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  <u>Diabetic Nephropathy</u>  <u>Congestive Heart Failure</u> <u>Diabetes Mellitus</u> <u>Anemia</u>  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>			
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)  28b. TIME OF INJURY <u>M</u> 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURED  28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <u>W. H. Hoard M.D.</u>			
29c. LICENSE NUMBER <u>D02386</u>				29d. DATE SIGNED (Month, Day, Year) <u>8/27/96</u>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>W. H. Hoard M.D. 3223 MAIN ST, MANCHESTER, MD 21102</u>				31. DATE FILED (Month, Day, Year) <u>AUG 28 1996</u>			
32. REGISTRAR'S SIGNATURE <u>Edson-Randall</u>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25513

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jacqueline Leola Witt

2. Date of Death

Month Day Year  
Aug. 25, 1996

3. Time of Death

6:30 pm.

4e. Facility Name (If not Institution, give street and number)

41 Glen Oak Ct.

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

218-28-9725

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

64

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year

Feb. 6, 1932

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

41 Glen Oak Ct.

10f. Zip Code

21158

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

State of Maryland

17. Father's Name (First, Middle, Last)

Perry McAtee

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Nutter

19a. Informant's Name/Relationship (Type, Print)

William J. Witt, Jr - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

41 Glen Oak Ct. Westminster, Md. 21158

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Maryland Veterans Cem. Aug. 28, 1996 Owings Mills, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

H. E. Ehrhardt

22. Name and Address of Facility

Eckhardt Funeral Chapel

21117

11605 Reisterstown Rd., Owings Mills, Md.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. VENTRICULAR ARRHYTHMIA

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1 MINUTE

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that Initiated events  
resulting in death) Last

b. CARDIAC ISCHEMIC EVENT

Due to (or as a consequence of):

5 MINUTES

c. ARTERIOSCLEROTIC-CARDIOVASCULAR-DISEASE

Due to (or as a consequence of):

10 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

H. E. Ehrhardt M.D.

29c. License number

D-22609

29d. Date signed (Month, Day, Year)

8/27/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

RUBEN REIDER M.D. 7445 FURNACE BRANCH RD GLEN BURNIE MD 21060

31. Date filed (Month, Day, Year)

AUG 28 1996

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 17 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
900-555-1234.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

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State of Maryland / Department of Health and Mental Hygiene  
item #19b, filmg 738, 8/28/96, cyw, per fr  
96 25514  
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>REGINALD WAY</b>		2. Date of Death Month <b>AUGUST</b> Day <b>25</b> Year <b>1996</b>		3. Time of Death <b>1:48 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>SHOCK TRAUMA</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>216-92-9943</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>17</b> Yrs.	
	8. Date of Birth (Month, Day, Year) <b>Mar. 11, 1979</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>			
To Be Completed by Funeral Director	Usual Residence of Decedent					
	10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>	
	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
	10e. Street and Number <b>3327 Burleith Avenue</b>		10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th</b> College (1-4 or 5+) <b>N/A</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>N/A</b>		16b. Kind of Business/Industry <b>N/A</b>	
	17. Father's Name (First, Middle, Last) <b>Reginald Way, Sr.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Danita Marie Black</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Danita Marie Black/mother</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3327 Burleith Ave., Baltimore, MD 21215</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Memorial Park</b>		20c. Location - City or Town, State <b>8/29 Randallstown, MD</b>	
21. Signature of Funeral Service Licensee <i>Leroy O. Dyett</i>		22. Name and Address of Facility <b>LEREOY O. DYETT &amp; SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE., BALTO. 21207</b>				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Gunshot wound of the chest</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>					Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined					
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	28a. Date of Injury (Month, Day Year) <b>8-25-96</b>		28b. Time of Injury <b>0121</b> M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred <b>Subject was shot</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Street</b>			
	28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>200 Black Greene St. Baltimore City, Maryland</b>					
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
State Registrar	29b. Signature and title of certifier <i>Dennis J. Chute</i>		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 25, 1996</b>	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>AUG 28 1996</b>		32. Registrar's Signature <i>Julia Davidson-Randall</i>				




Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25515

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FREDDIE YARBEROUGH SR.</b>				2. Date of Death Month Day Year <b>AUGUST 27, 1996</b>		3. Time of Death <b>6:30 a</b>	
	4a. Facility Name (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>212-30-8786</b>		6. Sex <b>1</b> M <b>2</b> F		7. Age (In yrs. last birthday) <b>61</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>OCT 3, 1934</b>	
	9. Birthplace (State or Foreign Country) <b>SC.</b>		10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <b>X</b> Yes <b>2</b> No				10e. Street and Number <b>4012 GELSTON DRIVE</b>		10f. Zip Code <b>21229</b>	
	10g. Citizen of What Country? <b>USA</b>				11. Marital Status <b>1</b> Never Married <b>X</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>X</b> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10TH</b> College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CRAN OPERATOR</b>				16b. Kind of Business/Industry <b>STEEL</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>ISIAH YARBEROUGH</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>CLARA HILL</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>JACQUELINE YARBEROUGH (WIFE)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4012 GELSTON DR. BALTO, MD. 21229</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <b>X</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>KING MEM PARK</b>		20c. Location - City or Town, State <b>8/31/96 RANDALLSTOWN, MD.</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>CAPLE FUNERAL SERVICE</b> <b>5502 WINNER AVE. BALTO, MD. 21215</b>			
To Be Completed by Physician/Medical Examiner	23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Bacterial Sepsis</b> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Renal Failure</b> <b>Hepatitis</b>						Approximate Interval Between Onset and Death <b>3 days</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Renal Failure</b> <b>Hepatitis</b>						23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No				24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No			
	25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No				26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death <b>1</b> Natural <b>5</b> Pending Investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide		28a. Date of Injury (Month, Day, Year) <b>8/31/96</b>		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier 				29c. License number <b>N9381</b>		29d. Date signed (Month, Day, Year) <b>August 27, 1996</b>	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Whittemore G. Tingley Johns Hopkins Hospital, Tower 110</b>							
	31. Date filed (Month, Day, Year) <b>AUG 28 1996</b>				32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

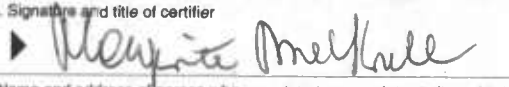
Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROBERT Clarke ABELL				2. Date of Death Month Day Year AUGUST 10, 1996		3. Time of Death 7:48 PM								
	4a. Facility Name (If not institution, give street and number) NORTHWEST HOSPITAL				4b. City, Town, or Location of Death Randallstown BALTIMORE		4c. County of Death BALTIMORE								
Funeral Director	5. Social Security Number 218-34-0164		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 59 Yrs.		8. Date of Birth (Month, Day, Year) July 13, 1937		9. Birthplace (State or Foreign Country) Maryland						
	Usual Residence of Decedent														
To Be Completed by Funeral Director	10a. State Maryland		10b. County Carroll		10c. City, Town or Location Westminster				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
	10e. Street and Number 3934 Baker Road				10f. Zip Code 21157		10g. Citizen of What Country? United States								
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1954-1963		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade		College (1-4 or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Chief investigator Licensing & Regulation Dept.			16b. Kind of Business/Industry State of Maryland							
	17. Father's Name (First, Middle, Last) Joseph Arthur Abell, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Madeline Rose Holston										
	19a. Informant's Name/Relationship (Type, Print) Charlotte A. Abell (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3934 Baker Road Westminster, MD 21157										
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremation, Inc.		Date 8/15/96		20c. Location - City or Town, State Hampstead, Maryland								
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, MD 21784										
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SURDACHNOID HEMORRHAGE Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
										24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred							
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier  M.D.		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) AUGUST 11, 1996	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Mary Ann McNeill 111 Penn Street, Baltimore, Maryland 21201															
31. Date filed (Month, Day, Year) AUG 16 1996		32. Registrar's Signature 													

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25517

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Bertha Wilson Allen				2. Date of Death Month Day Year August 11, 1996				3. Time of Death 11:59 PM	
	4a. Facility Name (If not Institution, give street and number) 3638 Edelman Terrace				4b. City, Town, or Location of Death Silver Spring				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 578-62-5238M		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 92 Yrs.		8. Date of Birth (Month, Day, Year) June 24, 1904		9. Birthplace (State or Foreign Country) Maine	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 3638 Edelman Terrace				10f. Zip Code 20906		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) Henry O. Wilson				18. Mother's Name (First, Middle, Maiden Surname) Flora G. Hillman					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Judith A. Stelson				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1307 Aquia Drive, Stafford, VA 22554					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		20c. Date 8-12-96		20d. Location - City or Town, State Beltsville, Maryland			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		26a. Date of Injury (Month, Day, Year)		26b. Time of Injury M		26c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		26d. Describe how injury occurred		
26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		26f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 				29c. License number D 24543		29d. Date signed (Month, Day, Year) August 12, 1996				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James A. Rossi, M. D., 3305 North Leisure World Blvd., Silver Spring, MD 20906										
31. Date filed (Month, Day, Year) AUG 13 1996		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25518

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Thurman D. Broyles				2. Date of Death Month Day Year June 26 1996		3. Time of Death 9:30 a.m.		
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick		
Funeral Director	5. Social Security Number 215-07-6456		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 2, 1914		
	9. Birthplace (State or Foreign Country) Md.								
To Be Completed by Funeral Director	Usual Residence of Decedent				10a. State Md.		10b. County Frederick		
	10c. City, Town or Location Burkittsville				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number 8 E. Main St.				10f. Zip Code 21718		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) small business administrator		16b. Kind of Business/Industry defense contractor				
	17. Father's Name (First, Middle, Last) Walter Broyles				18. Mother's Name (First, Middle, Maiden Surname) Edna Streeter				
	19a. Informant's Name/Relationship (Type, Print) Mary K. Broyles (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 E. Main St., Burkittsville, Md. 21718				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Locust Valley Cemetery		Date 6/29		20c. Location - City or Town, State Middletown, Md.		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Donald B. Thompson Funeral Home 31 E. Main St., Middletown, Md. 21769				
	Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiac arrhythmic Due to (or as a consequence of): Coronary artery disease Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. Due to (or as a consequence of):							Approximate Interval Between Onset and Death sudden 13 years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. upper GI bleed - aortic valve replacement - cerebrovascular accident poly myositis							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred					
28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier Austin Pearre				29c. License number D09689		29d. Date signed (Month, Day, Year) 6/27/96			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Austin A. Pearre 300 W 9th Street, Frederick Md.									
31. Date filed (Month, Day, Year) JUN 27 1996				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25519

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charlotte Marie Barbour				2. Date of Death Month Day Year August 20, 1996		3. Time of Death 10:58 a.m.	
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital				4b. City, Town, or Location of Death Takoma Park		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 577-40-3759		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) 07/28/1911	
	9. Birthplace (State or Foreign Country) Virginia		10a. State Md.		10b. County Prince George		10c. City, Town or Location Mitchellville	
To Be Completed by Funeral Director	10d. Inadequate City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 883 St. Michaels Drive		10f. Zip Code 20721		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Housewife		17. Father's Name (First, Middle, Last) Travis Berkley Daniel	
	18. Mother's Name (First, Middle, Maiden Surname) Charlotte Marie Daniel		19a. Informant's Name/Relationship (Type, Print) Ora Johnson (daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 883 St. Michaels Dr. Mitchellville, Md. 20721		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
Physician /Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Shady Grove Ch. Cem.		20c. Date 8/24/96		20d. Location - City or Town, State Orange County		21. Signature of Funeral Service Licensee Joseph W. Preddy #00204	
	22. Name and Address of Facility Preddy Funeral Home P.O. Box 321 Orange, Va. 22960		23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Septic Shock Due to (or as a consequence of): b. Urinary Tract Infection Due to (or as a consequence of): c. Multiple Cerebral Infarcts Due to (or as a consequence of): d. Atherosclerotic Heart Disease		Approximate Interval Between Onset and Death 1 week 1 week years years		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
	29b. Signature and title of certifier K. Sudhakar, M.D.		29c. License number D19971		29d. Date signed (Month, Day, Year) 8/20/96		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K. Sudhakar, M.D. 7610 Carroll Ave. #230 Takoma Park, MD 20912	
State Registrar	31. Date filed (Month, Day, Year) AUG 28 1996		32. Registrar's Signature John Thompson-Randall		33. Registrar's Title Registrar		34. Registrar's Office Division of Vital Records	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25520

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James Luther Bushey Jr.

2. Date of Death

Month 8 Day 13 Year 96

3. Time of Death

620PM

4a. Facility Name (If not institution, give street and number)

Carroll County General Hospital

4b. City, Town, or Location of Death

Sykesville

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

217-46-1085

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

60

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 13, 1936

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Sykesville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5122 Bushey Road

10f. Zip Code

21784

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Professional Land Surveyor

16b. Kind of Business/Industry

Residential

17. Father's Name (First, Middle, Last)

James L. Bushey, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Marian Reifsnider

19a. Informant's Name/Relationship (Type, Print)

Susan K. Bushey Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5122 Bushey Road Sykesville, MD 21784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Lake View Mem. Park

Date

8/16/96

20c. Location - City or Town, State

Sykesville, MD

21. Signature of Funeral Service Licensee

Jana B. Conroy

22. Name and Address of Facility

Burrier-Queen Funeral Directors, P.A.  
1212 W. Old Liberty Road Winfield, MD 2178423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Respiratory Arrest

Approximate  
Interval Between  
Onset and Death

72 hrs

Due to (or as a consequence of):

b. Cerebrovascular Accident

72 hrs

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypercholesterolemia  
Diabetes Type II A

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Robert P. Reckert

29c. License number

D39296

29d. Date signed (Month, Day, Year)

8/13/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R. Ricketts MD CCGH Westminster MD 21157

31. Date filed (Month, Day, Year)

AUG 16 1996

32. Registrar's Signature

John A. Anderson

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



96 25521

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Ferne Maxine Bainer</b>				2. DATE OF DEATH MONTH DAY YEAR <b>August 9, 1996</b>		3. TIME OF DEATH <b>11:00 PM</b>	
4. SOCIAL SECURITY NUMBER <b>215-34-3283</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec. 28, 1913</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Arkansas</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Fairland Adventist Nursing &amp; Rehabilitation Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Silver Spring</b>	
9c. COUNTY OF DEATH <b>Montgomery</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince Georges</b>	
10c. CITY, TOWN OR LOCATION <b>Upper Marlboro</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>12102 Molly Berry Road</b>	
10f. ZIP CODE <b>20772</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Nurse</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Health Care</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Clyde E. Bell</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Cora Lee Tucker</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Donald Eugene Bainer</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12102 Molly Berry Road Upper Marlboro, Maryland 20772</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Parklawn Memorial Park 8/13/96 Rockville, Maryland</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Steven Stand</i>				22. NAME AND ADDRESS OF FACILITY <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiovascular Disease</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Cerebrovascular Disease</b>							
DUE TO (OR AS A CONSEQUENCE OF): <b>Hypertension</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hemiplegia</b>							
<b>Dysphagia - G Tube placement</b>							
<b>Seizure Disorder</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>Patricia S. Armstrong M.D.</b>			
29c. LICENSE NUMBER <b>D42618</b>				29d. DATE SIGNED (Month, Day, Year) <b>08-10-1996</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>PATRICIA S. Armstrong M.D. 14448 Cherry Ln Ct #100 LAUREL, MD</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 12 1996</b>				32. REGISTRAR'S SIGNATURE <i>Lia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25522

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Agnes M. Bohac

2. Date of Death

August 7, 1996

3. Time of Death

3:15P.M.

4a. Facility Name (If not institution, give street and number)

Mariner Health Care of Greater Laurel

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

578-56-4575

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

100 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

February 13, 1896

9. Birthplace (State or Foreign Country)

Nebraska

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Beltsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11622 35th Place

10f. Zip Code

20705

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

5

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Henry

Maly

18. Mother's Name (First, Middle, Maiden Surname)

Josephine Vican

19a. Informant's Name/Relationship (Type, Print)

Evelyn Paradis

(daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as #10

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

8/10/1996

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Donald V. Borgwardt

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.

4400 Powder Mill Rd. Beltsville, Maryland 20705

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Arteriosclerotic Cardio Vascular Disease

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Old Age

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending Investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Medical Examiner2 ☒ Certifying Physician

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joselito D. Magday

29c. License number

D13687

29d. Date signed (Month, Day, Year)

August 8, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joselito D. Magday, M.D. 11701 Roby Avenue Beltsville, Maryland 20705

31. Date filed (Month, Day, Year)

AUG 12 1996

32. Registrar's Signature

Joselito D. Magday

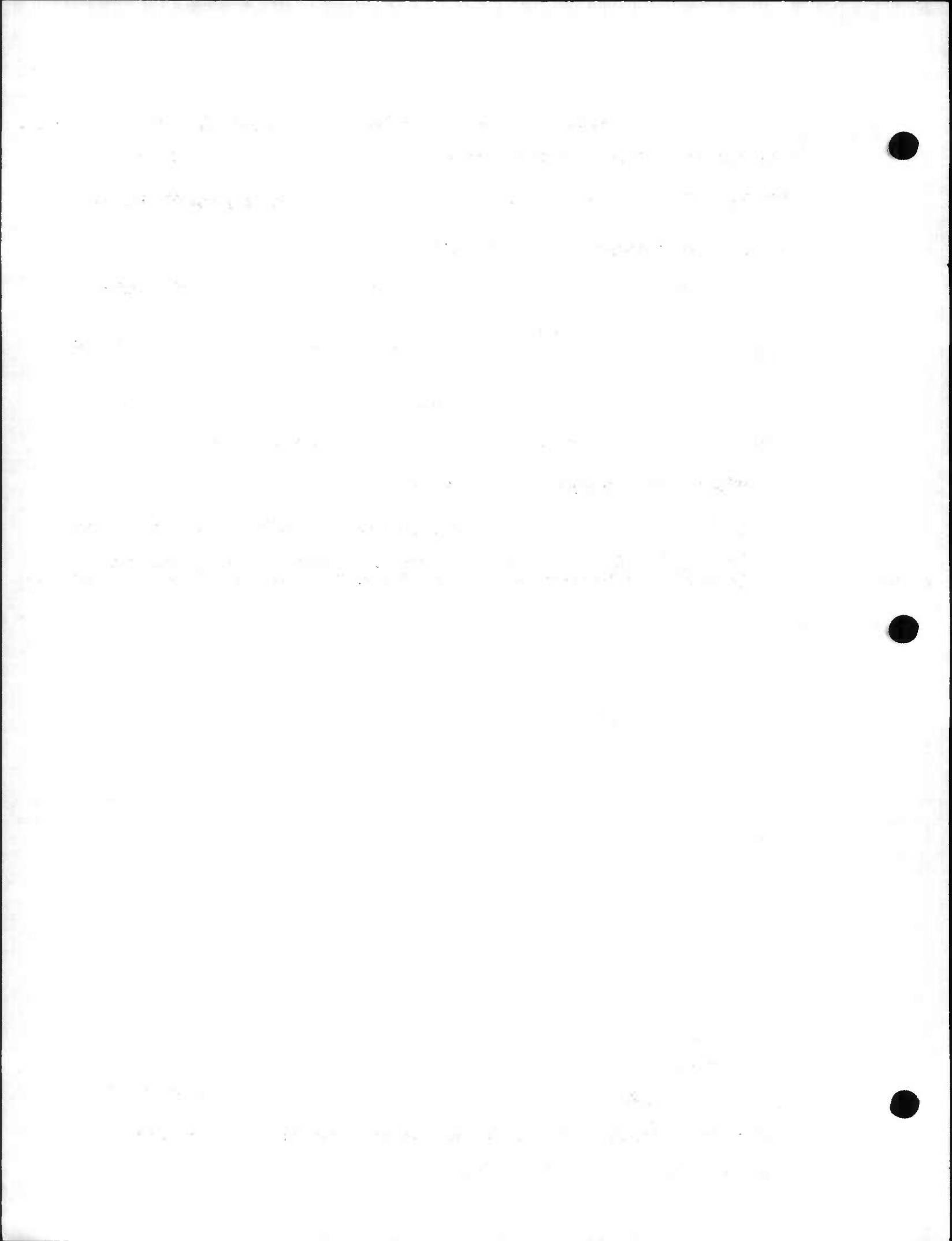
State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25523

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) ROBERT LEE BURRISS JR.				2. Date of Death Month Day Year AUGUST 14, 1996		3. Time of Death 10:00 AM	
	4a. Facility Name (If not institution, give street and number) 14821 LAYHILL ROAD				4b. City, Town, or Location of Death SILVER SPRING		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 212-38-3344		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 53 Yrs.		8. Date of Birth (Month, Day, Year) DEC. 17, 1942	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MARYLAND		10b. County MONTGOMERY		10c. City, Town or Location SILVER SPRING	
To Be Completed by Funeral Director	10e. Street and Number 14821 LAYHILL ROAD		10f. Zip Code 20906		10g. Citizen of What Country? UNITED STATES		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LANDSCAPER		16b. Kind of Business/Industry LANDSCAPING			
	17. Father's Name (First, Middle, Last) ROBERT LEE BURRISS, SR.				18. Mother's Name (First, Middle, Maiden Surname) ETHEL ABBEY THOMPSON			
	19a. Informant's Name/Relationship (Type, Print) PATSY L. BURRISS, WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14821 LAYHILL ROAD, SILVER SPRING, MD. 20906			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) SALEM CEMETERY		20c. Location - City or Town, State 8/19/96 BROOKEVILLE, MD.			
	21. Signature of Funeral Service Licensee Muriel H. Barber				22. Name and Address of Facility MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. VENTRICULAR FIBRILLATION TERMINAL Due to (or as a consequence of): b. Due to (or as a consequence of): c. Acute MYOCARDIAL INFARCTION TERMINAL Due to (or as a consequence of): d. {							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
State Registrar	29b. Signature and title of certifier Donald R. Lewis MD		29c. License number D06406		29d. Date signed (Month, Day, Year) AUGUST 14, 1996			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DONALD R. LEWIS MD RT108 OLNEY MD 20832							
31. Date filed (Month, Day, Year) AUG 16 1996				32. Registrar's Signature Davidson-Rodella				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

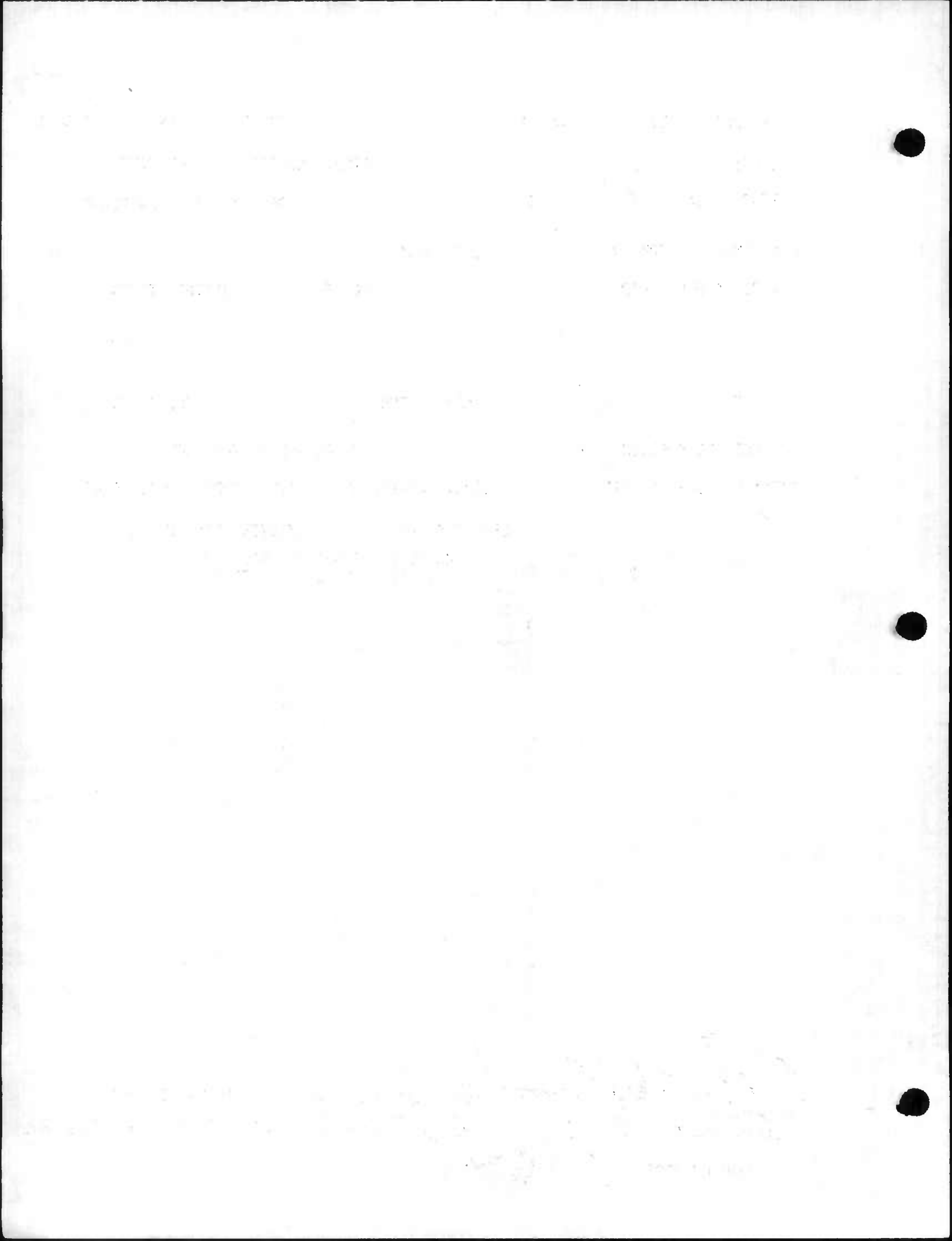
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25524

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Aaron M Brown

2. Date of Death

Aug 10 1996

3. Time of Death

8 AM

4a. Facility Name (If not institution, give street and number)

Hyattsville Manor

4b. City, Town, or Location of Death

Hyattsville

4c. County of Death

Prince George

Funeral  
Director

5. Social Security Number

224-08-3344

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

34 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

07 26 62

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

D. C.

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

401 Madison Street, N. E.

10f. Zip Code

20011

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Fashion Designer

16b. Kind of Business/Industry

Private Industry

17. Father's Name (First, Middle, Last)

George Richard McGee

18. Mother's Name (First, Middle, Maiden Surname)

Shirley E. Brown

19a. Informant's Name/Relationship (Type, Print)

Keith M. Brown (Brother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

603 Elizabeth Ave., #4E, Newark, NJ, 07112

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

8-14-96

20c. Location - City or Town, State

Alexandria, Va.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

R. N. Horton Co. Morticians, Inc.  
600 Kennedy Street, N. W., Wash., DC 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Aids  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

For years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Pneumonia  
Due to (or as a consequence of):

one month

c. Cardiopulmonary Failure  
Due to (or as a consequence of):

Immediate

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal Disease

Anemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D28906

29d. Date signed (Month, Day, Year)

August 10, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert F. O. Skipworth, MD; 585 MAIN STREET, LAUREL, MD 20707

31. Date filed (Month, Day, Year)

AUG 15 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

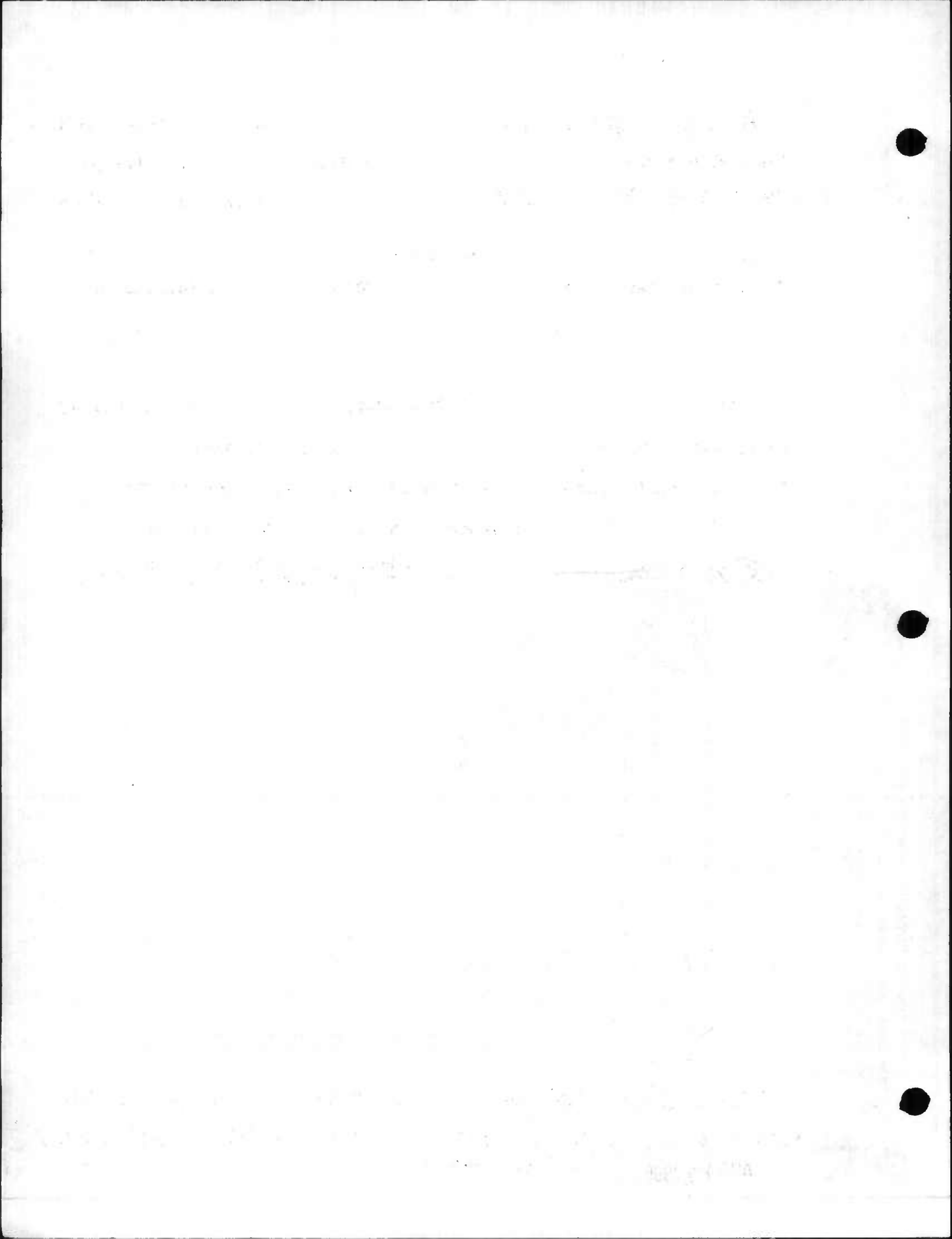
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25525

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>OREM FRANKLIN CARROLL, JR.</b>			2. Date of Death Month Day Year <b>August 14 96</b>		3. Time of Death <b>4:44 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>The Memorial Hospital at Easton, MD</b>			4b. City, Town, or Location of Death <b>Easton</b>		4c. County of Death <b>Talbot</b>	
Funeral Director	5. Social Security Number <b>216-38-3748</b>		8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F <b>XX</b>	7. Age (In yrs. last birthday) <b>54</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>APR. 28, 1942</b>
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>						
Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>TALBOT</b>		10c. City, Town or Location <b>EASTON</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>29383 STONEYRIDGE CIRCLE</b>				10f. Zip Code <b>21601</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SALESPERSON</b>		16b. Kind of Business/Industry <b>FARM EQUIPMENT</b>	
17. Father's Name (First, Middle, Last) <b>OREM F. CARROLL, SR.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>EVELYN EVANS</b>			
19a. Informant's Name/Relationship (Type, Print) <b>KATHRYN M. CARROLL/WIFE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>29383 STONEYRIDGE CIRCLE, EASTON, MD 21601</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MD. VETERAN CEMETERY 8-16</b>		Date <b>HURLOCK, MD</b>		20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee <b>M. E. Newnam CFSP</b>				22. Name and Address of Facility <b>FELLOWS, HELFENBEIN &amp; NEWNAM FUNERAL HOME 200 S. HARRISON ST., EASTON, MD</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Renal cell cancer</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
Approximate Interval Between Onset and Death <b>3 mo</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <b>Stephen P. Carney</b>		29c. License number <b>301225</b>		29d. Date signed (Month, Day, Year) <b>8-15-96</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>STEPHEN P. CARNEY, M.D., 509 IDLEWILD AVENUE, EASTON, MD 21601</b>							
31. Date filed (Month, Day, Year) <b>AUG 15 1996</b>		32. Registrar's Signature <b>John A. Anderson-Randall</b>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

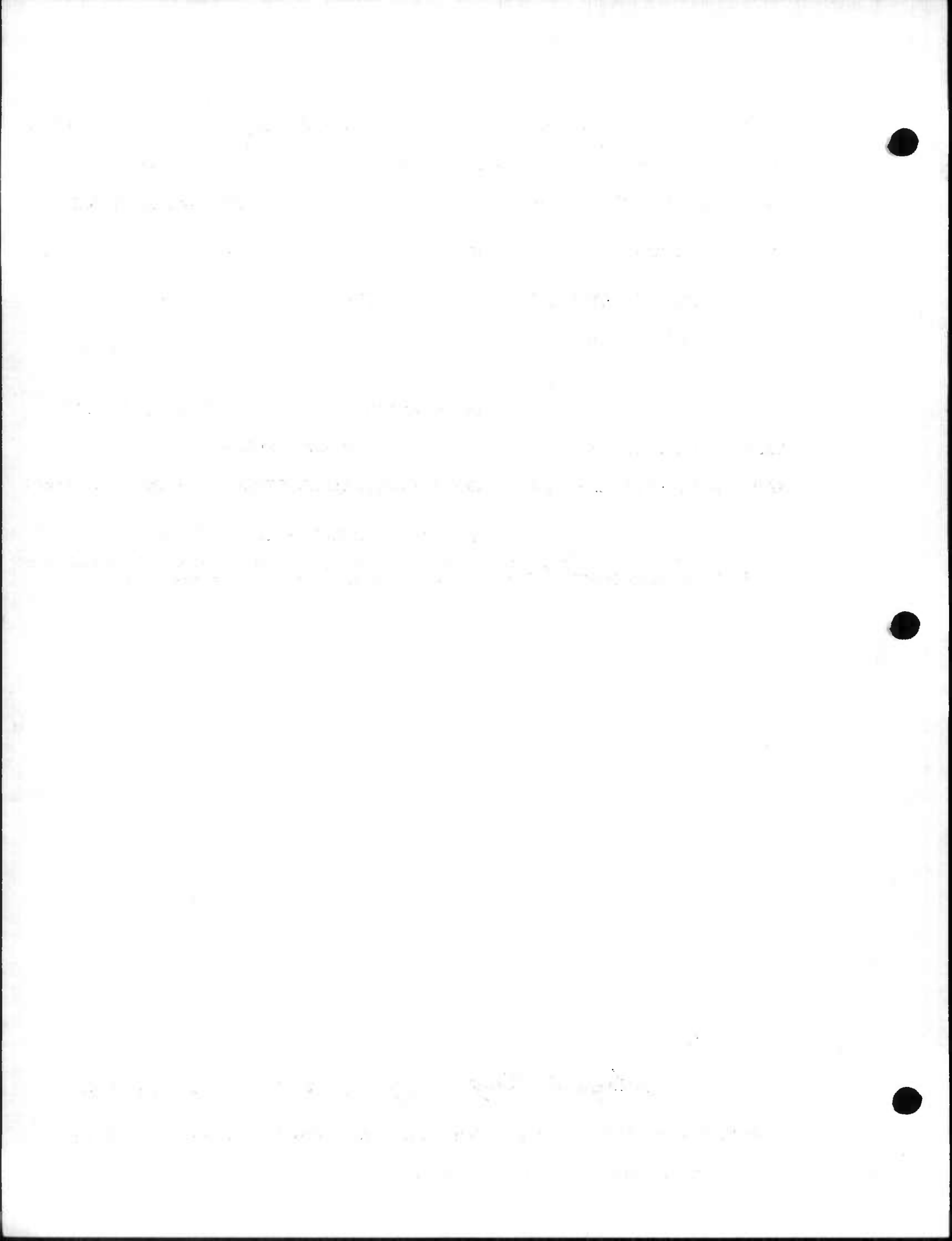
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25526

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret E. Clark				2. Date of Death Month Day Year August 3, 1996		3. Time of Death 2:00 P.M.	
	4a. Facility Name (If not institution, give street and number) Waterview Nursing Home				4b. City, Town, or Location of Death Salisbury		4c. County of Death Wicomico	
Funeral Director	5. Social Security Number 217-52-8099		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 47 Yrs.		8. Date of Birth (Month, Day, Year) Apr. 8, 1949	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Dorchester		10c. City, Town or Location Cambridge	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 807 Robbins Street		10f. Zip Code 21613	
	10g. Citizen of What Country? USA				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer			
	16b. Kind of Business/Industry Domestic				17. Father's Name (First, Middle, Last) Vernon Scott			
	18. Mother's Name (First, Middle, Maiden Surname) Daisy Thomas				19a. Informant's Name/Relationship (Type, Print) Bertha Northam			
	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 807 Robbins Street, Cambridge, Md. 21613				20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			
	20b. Place of Disposition (Name of cemetery, crematory or other place) Bethel A.M.E. Church Cem.				20c. Date 8/7/96		20d. Location - City or Town, State Cambridge	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Bennie Smith Funeral Home P.O. Box 1687, Easton, Maryland 21601			
	23a. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Stage IV gastric adenocarcinoma Due to (or as a consequence of): b. AIDS Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 2 Wk. 6 Yr.			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D32014		29d. Date signed (Month, Day, Year) 8/12/96		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) M. MOUNDRY 547-E RIVERSIDE DRIVE SALISBURY MD 21801								
31. Date filed (Month, Day, Year) AUG 13 1996		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

96 25527

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FRANCES VIOLA CLEM</b>				2. Date of Death Month Day Year <b>AUGUST 12, 1996</b>		3. Time of Death <b>05:45 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>8120 APPLES CHURCH ROAD</b>				4b. City, Town, or Location of Death <b>THURMONT</b>		4c. County of Death <b>FREDERICK</b>	
Funeral Director	5. Social Security Number <b>215-20-9384</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>72</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>MARCH 1, 1924</b>	
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10a. State <b>MARYLAND</b>		10b. County <b>FREDERICK</b>		10c. City, Town or Location <b>THURMONT</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>8120 APPLES CHURCH ROAD</b>		10f. Zip Code <b>21788</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status 1 <input type="checkbox"/> Navar Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry			
	17. Father's Name (First, Middle, Last) <b>MAURICE M. STAMBAUGH</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ETHEL M. FAVORITE</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>HARVEY CLEM, JR. / HUSBAND</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8120 APPLES CHURCH ROAD, THURMONT, MARYLAND 21788</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>RESTHAVEN MEMORIAL GRDNS</b>		20c. Date <b>8/14</b>		20d. Location - City or Town, State <b>FREDERICK, MARYLAND</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>ROBERT E. DAILEY &amp; SON FUNERAL HOMES, P.A. 615 EAST MAIN STREET, THURMONT, MARYLAND 21788</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>2003 cardiac arrhythmia</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death <b>6-12 mo</b>
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Breast cancer with liver mets</b> <b>ascites</b> <b>chronic pain</b>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier 				29c. License number <b>014672</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 13, 1996</b>	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>P. GREGORY RAUSCH, M.D., 501 WEST SEVENTH STREET, FREDERICK, MARYLAND 21701</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>AUG 12 1996</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene 96 25528

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Ruth Cullop				2. Date of Death Month: August Day: 12 Year: 1996		3. Time of Death 10:08 PM	
	4a. Facility Name (If not Institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 215-38-2625		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 12, 1917	
	9. Birthplace (State or Foreign Country) Virginia		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 614 Biggs Ave.		10f. Zip Code 21701		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry own home		16c. Kind of Business/Industry	
	17. Father's Name (First, Middle, Last) Jacob S. Atwell		18. Mother's Name (First, Middle, Maiden Surname) Ethel Mae McClellan		19a. Informant's Name/Relationship (Type, Print) James W. Cullop (son)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1014 Crown St./ Mt. Airy, Maryland 21771	
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Memorial		20c. Location - City or Town, State Frederick, Maryland		20d. Location - City or Town, State	
	21. Signature of Funeral Service Licensee <i>Raymond Peterson</i>		22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick, Md. 21702		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Metastatic lung cancer</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 3 mo	
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension</i>				23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28b. Location (Street and Number or Rural Route Number, City or Town, State)		28c. Describe how Injury occurred			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Gene Subkow</i>		29c. License number 031058		29d. Date signed (Month, Day, Year) 8-13-96	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gene Subkow, 60200 Coppermine Rd, Woodbury, MD 21798		31. Data filed (Month, Day, Year) AUG 16 1996					
	32. Registrar's Signature <i>John A. Roshell</i>		33. Registrar's Signature					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

96 25529

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Rose Elaine Cummings

2. Date of Death

Month Day Year  
August 8, 1996

3. Time of Death

1:00pm

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

577-72-9153

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

56 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 8, 1940

9. Birthplace (State or Foreign Country)

Jamaica

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6420 Stream Valley Way

10f. Zip Code

20882

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

General Manager

16b. Kind of Business/Industry

Food Distribution

17. Father's Name (First, Middle, Last)

Lincoln George Chin

18. Mother's Name (First, Middle, Maiden Surname)

Ruby Olivia Delgado

19a. Informant's Name/Relationship (Type, Print)

Keith A. Cummings

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6420 Stream Valley Way, Gaithersburg, MD 20882

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gate of Heaven Cemetery 8/14/96 Silver Spring, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Steven J. Stenel

22. Name and Address of Facility Francis J. Collins Funeral  
Home, Inc. 500 University Blvd. West  
Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Lung Cancer

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

6 Months

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Patrick Cross M.D.

29c. License number

D41728

29d. Date signed (Month, Day, Year)

August 11, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Patrick Cross, M.D. 110 Irving Street, NW Suite 3A-3, Washington DC 20010

31. Date filed (Month, Day, Year)

AUG 13 1996

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25530

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Arthur P. Chase				2. Date of Death Month August 5 Day Year 1996		3. Time of Death 7:47 AM			
	4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital				4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery			
Funeral Director	5. Social Security Number 114-09-0136		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 14, 1920		9. Birthplace (State or Foreign Country) New York	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Potomac			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 11204 Old Post Road				10f. Zip Code 20854		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Civil Engineer			16b. Kind of Business/Industry Private Sector				
	17. Father's Name (First, Middle, Last) Pantelis Chletsos				18. Mother's Name (First, Middle, Maiden Surname) Anastasia Edraios					
	19a. Informant's Name/Relationship (Type, Print) Peter A. Chase / Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 Cherbourg Court, Potomac, Maryland 20854					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		Date 8/8/96		20c. Location - City or Town, State Silver Spring, Maryland			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Congestive Heart Failure Due to (or as a consequence of): b. Coronary Artery Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 1 Year 5 Years					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus Peripheral Artery Disease				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number 07162 MD		29d. Date signed (Month, Day, Year) August 5, 1996			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin Graf, M.D. 15225 Shady Grove Road, Rockville, Maryland 20850									
State Registrar	31. Date filed (Month, Day, Year) AUG 12 1996		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

96 25531

Amended #1, 8/16/96, JW, Mont. County

Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Robert F. Joseph

2. Date of Death

Month Day Year  
August 14 1996 7:50 P

3. Time of Death

4a. Facility Name (If not Institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

577-36-7474

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 16, 1930

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

North Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7009 Old Cabin Lane

10f. Zip Code

20852

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

1948-

1960

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Director

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Robert Peter Conlan

18. Mother's Name (First, Middle, Maiden Surname)

Josephine McGee

19a. Informant's Name/Relationship (Type, Print)

Karen V. Conlan/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7009 Old Cabin Lane, North Bethesda, MD 20852

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

August 17, 1996

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

David E. Perry M00803

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/  
Bethesda-Chevy Chase, Inc. 7557 Wisconsin  
Avenue, Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebral Metastatic disease

Due to (or as a consequence of):

b. Pulmonary metastatic disease

Due to (or as a consequence of):

c. Colon Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

3 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Electrolyte Imbalance

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Murmurke, M.D.

29c. License number

29816

29d. Date signed (Month, Day, Year)

August 15, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Radhey Murarka, M.D. 13900 Natia Manor Drive, North Potomac, MD 20878

31. Date filed (Month, Day, Year)

AUG 16 1996

32. Registrar's Signature

J. Chapman-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

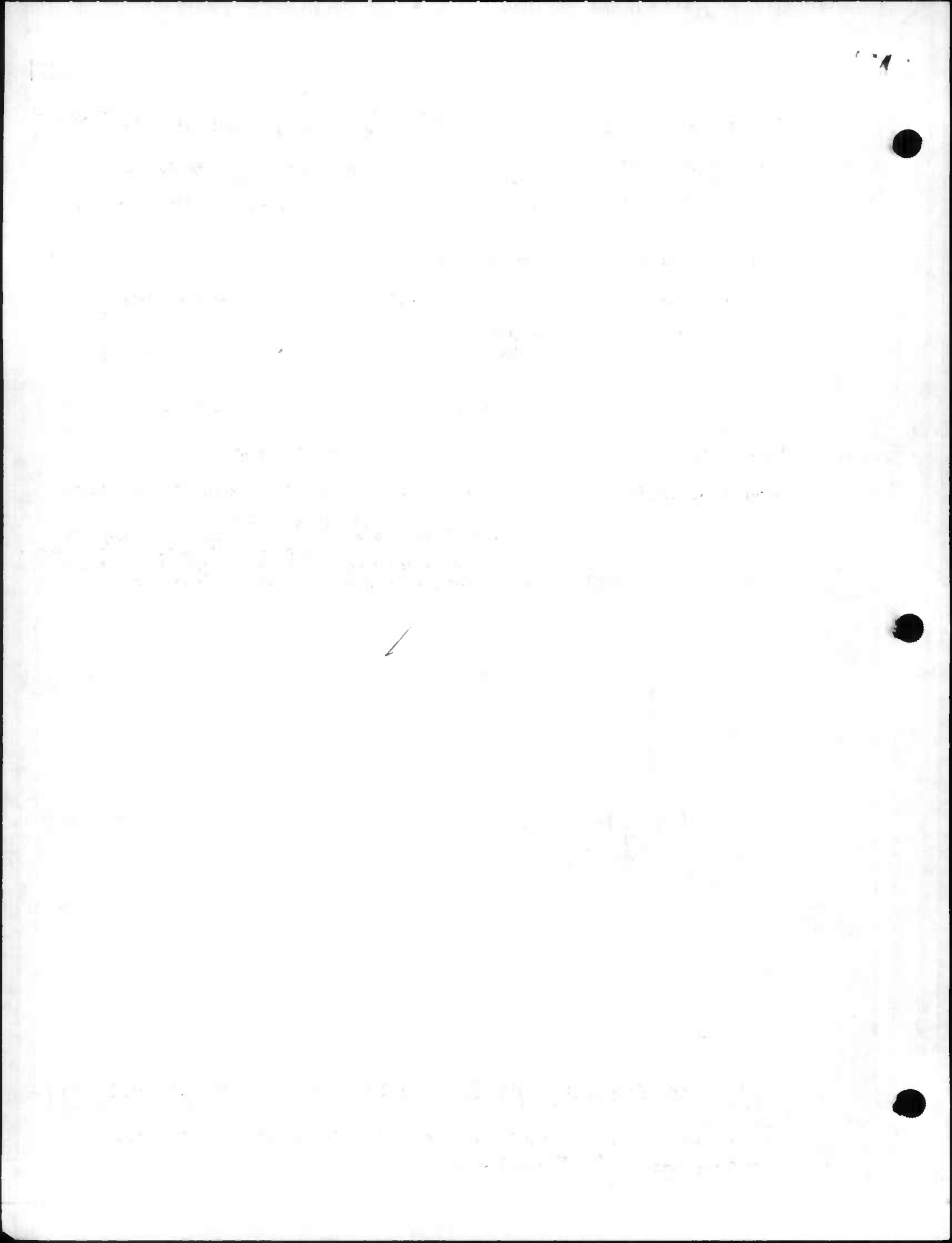
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

15x1



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25532

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GRACE ANN CARRIER						2. Date of Death Month Day Year AUGUST 11 1996		3. Time of Death 9:15 pm	
	4a. Facility Name (If not institution, give street and number) N.I.H. CLINICAL CENTER						4b. City, Town, or Location of Death BETHESDA		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 367-42-5563		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) 55 Yrs.		8. Date of Birth (Month, Day, Year) DEC. 4, 1940		9. Birthplace (State or Foreign Country) MICHIGAN	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State GA.		10b. County RICHMOND		10c. City, Town or Location AUGUSTA				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 2975 FOXHALL CIR.				10f. Zip Code 30907		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TEACHER			16b. Kind of Business/Industry PUBLIC SCHOOLS			
	17. Father's Name (First, Middle, Last) CHARLES P. HODGKINSON						18. Mother's Name (First, Middle, Maiden Surname) AMY V. WALKER			
	19a. Informant's Name/Relationship (Type, Print) GERALD O. CARRIER/HUSBAND				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS ITEM #10					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CHAMBERS CREMATORY		Date 8/13		20c. Location - City or Town, State RIVERDALE, MD.			
	21. Signature of Funeral Service Licensee W.W. Chambers				22. Name and Address of Facility W. W. CHAMBERS CO., RIVERDALE, MD. 20737					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MULTI ORGAN FAILURE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. METASTATIC BREAST CANCER (8 months)										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury et Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier Philippe C Bishop								
29c. License number D0050432		29d. Date signed (Month, Day, Year) 8/12/96								
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) PHILIPPE C. BISHOP, M.D. NATIONAL INSTITUTES OF HEALTH, BETHESDA, MD 20892										
31. Date filed (Month, Day, Year) AUG 14 1996										
32. Registrar's Signature J. Davidson-Randall										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25533

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Charles Edward CAMPBELL</b>				2. Date of Death Month Day Year <b>August 9, 1996</b>		3. Time of Death <b>1:54P</b>	
	4a. Facility Name (If not institution, give street and number) <b>DOCTORS COMMUNITY HOSPITAL</b>				4b. City, Town, or Location of Death <b>Lanham</b>		4c. County of Death <b>Prince George</b>	
Funeral Director	5. Social Security Number <b>217-32-5877</b>		6. Sex <b>15 M 2 F</b>		7. Age (In yrs. last birthday) <b>60</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan 25, 1936</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Md</b>		10b. County <b>Prince George</b>		10c. City, Town or Location <b>Lanham</b>	
Usual Residence of Decedent								
10a. State <b>Md</b>			10b. County <b>Prince George</b>			10c. City, Town or Location <b>Lanham</b>		
10d. Inside City Limits <b>XX</b> Yes 2 No			10e. Street and Number <b>7300 Powhatan Street,</b>			10f. Zip Code <b>20706</b>		
10g. Citizen of What Country? <b>U.S.A.</b>			11. Marital Status <b>1 Never Married 2X Married 3 Widowed 4 Divorced</b>			12. Was Decedent Ever in U.S. Armed Forces? <b>XX Yes 2 No</b> If Yes, Give Year or Dates:		
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2X No Specify:</b>			14. Race - American Indian, Black, White, etc. <b>Specify: Black</b>			15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 7th Grade Collage (1-4or 5+)</b>		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Truck Driver</b>			16b. Kind of Business/Industry <b>Trucking Co.</b>			17. Father's Name (First, Middle, Last) <b>Robert L. Campbell</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>Elsie Berry</b>			19a. Informant's Name/Relationship (Type, Print) (Sister) <b>Rosa Leigh Williams</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>639 Lincoln St, Rockville, Md 20850</b>		
20a. Method of Disposition <b>1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cem. Maryland Veterans</b>			20c. Location - City or Town, State <b>7/14 Cheltenham, Md</b>		
21. Signature of Funeral Service Licensee <i>[Signature]</i>			22. Name and Address of Facility <b>Snowden Funeral Home P.A. 20850 Rockville, Md</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Immediate Cause (Final disease or condition resulting in death): Sepsis</b> <b>Due to (or as a consequence of): Hepatic Failure</b> <b>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: Upper Gastrointestinal Bleeding</b>								
23b. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4X Unknown</b>								
24a. Was an autopsy performed? <b>1 Yes 2 No</b>								
24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Alcoholic Liver Disease</b>								
25. Was case referred to medical examiner? <b>1 Yes 2X No</b>			26. Place of Death (Check only one) Hospital: <b>1X Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>					
27. Manner of Death <b>1X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>			28a. Date of Injury (Month, Day, Year)			28b. Time of Injury <b>M</b>		
28c. Injury at Work? <b>1 Yes 2 No</b>			28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)			29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>					
29b. Signature and title of certifier <i>[Signature]</i> MD			29c. License number <b>D45560</b>			29d. Date signed (Month, Day, Year) <b>8-10-96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>3060, Mitchellville Rd, Bowie MD 20716</b>								
31. Date filed (Month, Day, Year) <b>AUG 13 1996</b>			32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25534

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Florence

2. Date of Death

Month Day Year  
August 8, 1996

3. Time of Death

1:20 AM

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

577-40-0503

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 21, 1916

9. Birthplace (State or Foreign Country)

Iowa

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13404 Keating Street

10f. Zip Code

20853

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Joseph Schmitt

18. Mother's Name (First, Middle, Maiden Surname)

Theresa Schneider

19a. Informant's Name/Relationship (Type, Print)

Patrick L. Conroy

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8417 Dasher Court, Gaithersburg, MD 20882

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gate of Heaven

Date

8/10/96 Silver Spring, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral  
Home, Inc. 500 University Blvd. West  
Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Acute Renal failure

Due to (or as a consequence of):

b. Cellulitis Right leg

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus II, myeloproliferative  
Syndrome, Acute Brain Syndrome  
Spontaneous pneumothorax

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeremy Cooke 10400 Conn Ave, Kensington Md

31. Date filed (Month, Day, Year)

AUG 12 1996

32. Registrar's Signature

John Davidson-Randall

State  
RegistrarBaltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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January 1st 1900

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25535

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Helen F. Carey</b>				2. Date of Death Month <b>August</b> Day <b>2</b> Year <b>1996</b>				3. Time of Death <b>1:10A.</b>	
	4a. Facility Name (If not Institution, give street and number) <b>Mariner Health Care of Greater Laurel</b>				4b. City, Town, or Location of Death <b>Laurel</b>				4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>577-36-1983</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>85</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept. 27, 1910</b>		9. Birthplace (State or Foreign Country) <b>Ohio</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Laurel</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>14200 Laurel Park Drive</b>				10f. Zip Code <b>20707</b>		10g. Citizen of What Country? <b>United States</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Clerk</b>			16b. Kind of Business/Industry <b>U.S. Government</b>		
	17. Father's Name (First, Middle, Last) <b>Thomas J. Moore</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Myrtle Wolfe</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Paul E. Runnion (son)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13131 Oriole Drive Beltsville, Maryland 20705</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Eventide Cemetery</b>		Data <b>8/8/96</b>		20c. Location - City or Town, State <b>Spencer, West Virginia</b>	
	21. Signature of Funeral Service Licensee <b>Donald V. Borgwardt</b>				22. Name and Address of Facility <b>Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Organic Brain Disease</b> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>3 years</b>									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b>									
Physician /Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										
28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <b>John Margolis, M.D.</b>					29c. License number <b>D25430</b>			29d. Date signed (Month, Day, Year) <b>August 2, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John Margolis, M.D. 14333 Laurel Bowie Rd., #307 Laurel, Maryland 20708-1160</b>										
State Registrar	31. Date filed (Month, Day, Year) <b>AUG 06 1996</b>				32. Registrar's Signature <b>Davidson-Randall</b>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25536

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Kathryn Bessey Chandler</b>				2. Date of Death Month <b>August</b> Day <b>3</b> Year <b>1996</b>				3. Time of Death <b>10:10pm</b>	
	4a. Facility Name (If not Institution, give street and number) <b>Wilson Health Care Center</b>				4b. City, Town, or Location of Death <b>Gaithersburg</b>				4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>036-05-3953</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>83</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>June 12, 1913</b>		9. Birthplace (State or Foreign Country) <b>Massachusetts</b>	
	Usual Residence of Decedent				10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Gaithersburg</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>301 Russell Avenue</b>				10f. Zip Code <b>20877</b>	
	10g. Citizen of What Country? <b>United States</b>				11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Collage</b>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Sales Associate</b>				16b. Kind of Business/Industry <b>Retail Sales</b>				17. Father's Name (First, Middle, Last) <b>M. Thomas Bessey</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>Viola Brackett</b>				19a. Informant's Name/Relationship (Type, Print) <b>Charles W. Chandler (son)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1211 Tory Road, Rockville, MD 20852</b>	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Glenwood Cemetery</b>				20c. Location - City or Town, State <b>8/9/96 Maynard, Massachusetts</b>	
	21. Signature of Funeral Service Licenses <b>Michael D. Hibbons</b>				22. Name and Address of Facility <b>DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877</b>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Artherosclerotic Cardiovascular Disease</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day Year)				28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		
29b. Signature and title of certifier <b>Joel R. Schulman MD</b>				29c. License number <b>D 20516</b>				29d. Date signed (Month, Day, Year) <b>August 5, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joel R. Schulman, MD 9410 old Georgetown Road, Bethesda, MD 20814</b>				31. Date filed (Month, Day, Year) <b>AUG 12 1996</b>				32. Registrar's Signature <b>Davidson-Rodell</b>		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25537

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Vera F. Cohee						2. Date of Death Month Day Year August 13, 1996		3. Time of Death 2:55 PM	
	4a. Facility Name (If not institution, give street and number) Potomac Valley Nursing Home						4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 577-72-2226		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) March 6, 1908		9. Birthplace (State or Foreign Country) Indiana	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Bethesda				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 5508 Namakagan Road				10f. Zip Code 20816		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) George R. French						18. Mother's Name (First, Middle, Maiden Surname) Callie Killion			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Nell M. Reed/Guardian				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5503 Namakagan Road, Bethesda, Maryland 20816					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment		20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Memorial Park			Date Aug. 16, 1996		20c. Location - City or Town, State Rockville, Maryland		
	21. Signature of Funeral Service Licensee Michelle P. Kutta M00348				22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 W. Montgomery Avenue, Rockville, Maryland 20850-2805					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. Septicemia Due to (or as a consequence of): Urosepsis Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last f. Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of):									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
State Registrar	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer's Dementia						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicidal 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Joseph D. Connor, M.D.		29c. License number D02047		29d. Date signed (Month, Day, Year) August 14, 1996			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Joseph D. Connor, M.D., 6000 Executive Blvd., #300, Rockville, Maryland 20852									
31. Date filed (Month, Day, Year) AUG 16 1996										
32. Registrar's Signature Joseph D. Connor										





Joseph V. Catania  
8/14/96 7:19 PM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25538

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joseph Vincent Catania				2. Date of Death Month Day Year August 14, 1996				3. Time of Death 7:19 PM			
	4a. Facility Name (If not institution, give street and number) Montgomery General Hospital				4b. City, Town, or Location of Death Olney				4c. County of Death Montgomery			
Funeral Director	5. Social Security Number 124-14-1319		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 2, 1917		9. Birthplace (State or Foreign Country) New York			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 3613 Tarkington Lane				10f. Zip Code 20906				10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Senior Auditor				16b. Kind of Business/Industry U.S. Government			
	17. Father's Name (First, Middle, Last) Philip Catania				18. Mother's Name (First, Middle, Maiden Surname) Annie Gianni							
	19a. Informant's Name/Relationship (Type, Print) Catherine R. Catania/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3613 Tarkington Lane, Silver Spring, MD 20906							
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Mausoleum				Date Aug. 17, 1996		20c. Location - City or Town, State Silver Spring, Maryland			
	21. Signature of Funeral Service Licensee Ray Faulk M00198				22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. Congestive Heart Failure Due to (or as a consequence of): 2 days b. Acute Myocardial Infarction Due to (or as a consequence of): 2 days c. Coronary Artery Disease Due to (or as a consequence of): 3 years d.										Approximate Interval Between Onset and Death	
	Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pneumonia acute renal insufficiency								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												
Medical Certification: To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
	29b. Signature and title of certifier James A. Rossi, M.D.				29c. License number D24543				29d. Date signed (Month, Day, Year) August 15, 1996			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James A. Rossi, MD. 3305 North Leisure World Blvd, Silver Spring MD 20906											
	31. Date filed (Month, Day, Year) AUG 16 1996				32. Registrar's Signature John Davidson							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



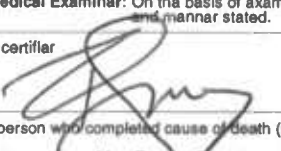
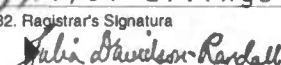
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State of Maryland / Department of Health and Mental Hygiene

96 25539

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>EARL WALLACE DONALDSON, SR.</b>				2. Date of Death Month Day Year <b>AUGUST 13 1996</b>		3. Time of Death <b>6:45 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>FORT WASHINGTON MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>FORT WASHINGTON</b>		4c. County of Death <b>PRINCE GEORGE'S</b>	
Funeral Director	5. Social Security Number <b>160-12-4688</b>		6. Sex <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>90</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>APRIL 2, 1906</b>	
	9. Birthplace (State or Foreign Country) <b>PENNSYLVANIA</b>		10a. State <b>MARYLAND</b>		10b. County <b>PRINCE GEORGE'S</b>		10c. City, Town or Location <b>FT. WASHINGTON</b>	
To Be Completed by Funeral Director	10a. Street and Number <b>13705 PISCATAWAY DRIVE</b>		10f. Zip Code <b>20744</b>		10g. Citizen of What Country? <b>UNITED STATES</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>1927-</b> If Yes, Give Year or Dates: <b>1937</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SUPERVISOR</b>		16b. Kind of Business/Industry <b>STEEL MANUFACTURER</b>		17. Father's Name (First, Middle, Last) <b>THOMAS DONALDSON</b>	
	18. Mother's Name (First, Middle, Maiden Summa) <b>AGNESS WITHERSPOON</b>		19a. Informant's Name/Relationship (Type, Print) <b>EARL W. DONALDSON, JR. - SON</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13705 PISCATAWAY DR., FT. WASHINGTON, MD. 20744</b>		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HUNTT CREMATORY</b>		20c. Location - City or Town, State <b>AUGUST 15, 1996 WALDORF, MARYLAND</b>		21. Signature of Funeral Service Licensee <b>MARK G. BROHAWN M00053</b>		22. Name and Address of Facility <b>THE HUNTT FUNERAL HOME, INC. P.O. BOX 156, WALDORF, MARYLAND 20604</b>	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. PNEUMONIA</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>		Approximate Interval Between Onset and Death <b>1 DAY</b>		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> <b>FRACTURED HIP</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>28b. Time of Injury</b> <b>28c. Injury at Work?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>28e. Location (Street and Number or Rural Route Number, City or Town, State)</b>		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
State Registrar	29b. Signature and title of certifier 		29c. License number <b>D19431</b>		29d. Date signed (Month, Day, Year) <b>August 13, 1996</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Frank M. Ryan M.D. 11701 Livingston Rd #203 Ft. Washington, MD 20744</b>	
	31. Date filed (Month, Day, Year) <b>AUG 16 1996</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1. The first part of the paper is devoted to the study of the properties of the function  $f(x)$  defined by the equation  $f(x) = \int_0^x f(t) dt$ . It is shown that  $f(x)$  is a constant function, and its value is determined by the initial condition  $f(0) = 1$ .

2. In the second part, we consider the function  $g(x)$  defined by the equation  $g(x) = \int_0^x g(t) dt + x$ . It is shown that  $g(x)$  is a linear function, and its value is determined by the initial condition  $g(0) = 0$ .

3. The third part of the paper is devoted to the study of the properties of the function  $h(x)$  defined by the equation  $h(x) = \int_0^x h(t) dt + x^2$ . It is shown that  $h(x)$  is a quadratic function, and its value is determined by the initial condition  $h(0) = 0$ .

4. In the fourth part, we consider the function  $k(x)$  defined by the equation  $k(x) = \int_0^x k(t) dt + x^3$ . It is shown that  $k(x)$  is a cubic function, and its value is determined by the initial condition  $k(0) = 0$ .

5. The fifth part of the paper is devoted to the study of the properties of the function  $l(x)$  defined by the equation  $l(x) = \int_0^x l(t) dt + x^4$ . It is shown that  $l(x)$  is a quartic function, and its value is determined by the initial condition  $l(0) = 0$ .

6. In the sixth part, we consider the function  $m(x)$  defined by the equation  $m(x) = \int_0^x m(t) dt + x^5$ . It is shown that  $m(x)$  is a quintic function, and its value is determined by the initial condition  $m(0) = 0$ .

7. The seventh part of the paper is devoted to the study of the properties of the function  $n(x)$  defined by the equation  $n(x) = \int_0^x n(t) dt + x^6$ . It is shown that  $n(x)$  is a sextic function, and its value is determined by the initial condition  $n(0) = 0$ .

8. In the eighth part, we consider the function  $p(x)$  defined by the equation  $p(x) = \int_0^x p(t) dt + x^7$ . It is shown that  $p(x)$  is a septic function, and its value is determined by the initial condition  $p(0) = 0$ .

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State of Maryland / Department of Health and Mental Hygiene

96 25540

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>John Dorosh</b>				2. Date of Death Month <b>August</b> Day <b>4</b> , Year <b>1996</b>		3. Time of Death <b>3:10pm</b>	
	4e. Facility Name (If not institution, give street and number) <b>Shady Grove Adventist Nursing Home</b>				4b. City, Town, or Location of Death <b>Rockville</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>055-09-9654</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>82</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 20, 1914</b>	
	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>		10a. State <b>Florida</b>		10b. County <b>Broward</b>		10c. City, Town or Location <b>Pembroke Pines</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number <b>13450 S.W. 3rd Street New Hampton D418</b>				10f. Zip Code <b>33027</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Postal Clerk</b>		16b. Kind of Business/Industry <b>U.S. Postal Service</b>			
	17. Father's Name (First, Middle, Last) <b>Michael Dorosh</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Helen Chawas</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>John Dorosh, Jr. (son)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14 Phillene Drive, Norwalk, Connecticut 06851</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Johns Cemetery</b>		Date <b>8/9/96</b>		20c. Location - City or Town, State <b>Norwalk, Connecticut</b>	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>DeVol Funeral Home</b> <b>10 East Deer Park Drive</b> <b>Gaithersburg, MD 20877</b>					
	23a. Part I. Note the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) e. <b>NONHODGKINS LYMPHOMA</b> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____							<b>8 Months</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D37236</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 5, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Carolyn B. Hendricks, MD 9707 Medical Center Dr. #300, Rockville, MD 20850</b>								
31. Date filed (Month, Day, Year) <b>AUG 12 1996</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

96 25541

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Alphonso Howard Edmonds

2. Date of Death

Month

Day

Year

August 14, 1996

3. Time of Death

6:08A

4a. Facility Name (If not institution, give street and number)

Dorchester General Hospital

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

Funeral  
Director

5. Social Security Number

218-84-9424

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

34 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Dorchester

10c. City, Town or Location

Cambridge

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

822- PARK Lane

10f. Zip Code

21613

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

9

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

General Maintenance

16b. Kind of Business/Industry

Housing

17. Father's Name (First, Middle, Last)

George Thomas Edmonds SR.

18. Mother's Name (First, Middle, Maiden Surname)

Gladys Bryant

19a. Informant's Name/Relationship (Type, Print)

Gladys Edmonds

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

820-PARK Lane Cambridge, Maryland 21613

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Airey Cemetery

Date

8/17/96

20c. Location - City or Town, State

Cambridge

21. Signature of Funeral Service Licensee

Janelle C. Henry

22. Name and Address of Facility

HENRY FUNERAL HOME

510 Washington St. Cambridge, MD, 21613

23a. Part I. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line.

Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. CARDIAC ARREST

18 hours

Due to (or as a consequence of):

b. CONGESTIVE HEART FAILURE

36 hours

Due to (or as a consequence of):

c. HIV ~~CA~~ CARDIOMYOPATHY

Due to (or as a consequence of):

d. HIV / AIDS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

N/A

28b. Time of Injury

N/A M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

N/A

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

N/A

28f. Location (Street and Number or Rural Route Number, City or Town, State)

N/A

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Janelle C. Henry

29c. License number

650271

29d. Date signed (Month, Day, Year)

08/15/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JANELLE A. BARNEY, MD

503A MUIR ST, CAMB, MD 21613

31. Date filed (Month, Day, Year)

AUG 15 1996

32. Registrar's Signature

John Andrew Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25542

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Perry T. Ewell, Sr.</b>				2. Date of Death Month <b>Aug.</b> Day <b>14</b> , Year <b>1996</b>		3. Time of Death <b>7:55 am</b>	
	4a. Facility Name (If not institution, give street and number) <b>5102 Aireys Road</b>				4b. City, Town, or Location of Death <b>Cambridge</b>		4c. County of Death <b>Dorchester</b>	
Funeral Director	5. Social Security Number <b>220-10-6056</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>79</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 19, 1917</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Dorchester</b>		10c. City, Town or Location <b>Cambridge</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>16 Meteor Ave., Apt. 906</b>		10f. Zip Code <b>21613</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Painter</b>		16b. Kind of Business/Industry <b>Painting Contractor</b>			
	17. Father's Name (First, Middle, Last) <b>Swain Ewell</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Nona (Maiden name unknown)</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>daughter</b> <b>Beverly Jones Ewell</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5102 Aireys Rd., Cambridge, MD. 21613</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dorchester Mem Pk</b>		20c. Location - City or Town, State <b>8-16 Cambridge, MD.</b>			
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD. 21613</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>a. Metastatic Bronchogenic Carcinoma</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>							
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how Injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>[Signature]</i>			
	29c. License number <b>D-28209</b>				29d. Date signed (Month, Day, Year) <b>August 16, 1996</b>			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Edmund J. MacLaughlin 4 Aurora St. Cambridge, Md 21613</b>							
31. Date filed (Month, Day, Year) <b>AUG 19 1996</b>				32. Registrar's Signature <i>[Signature]</i>				

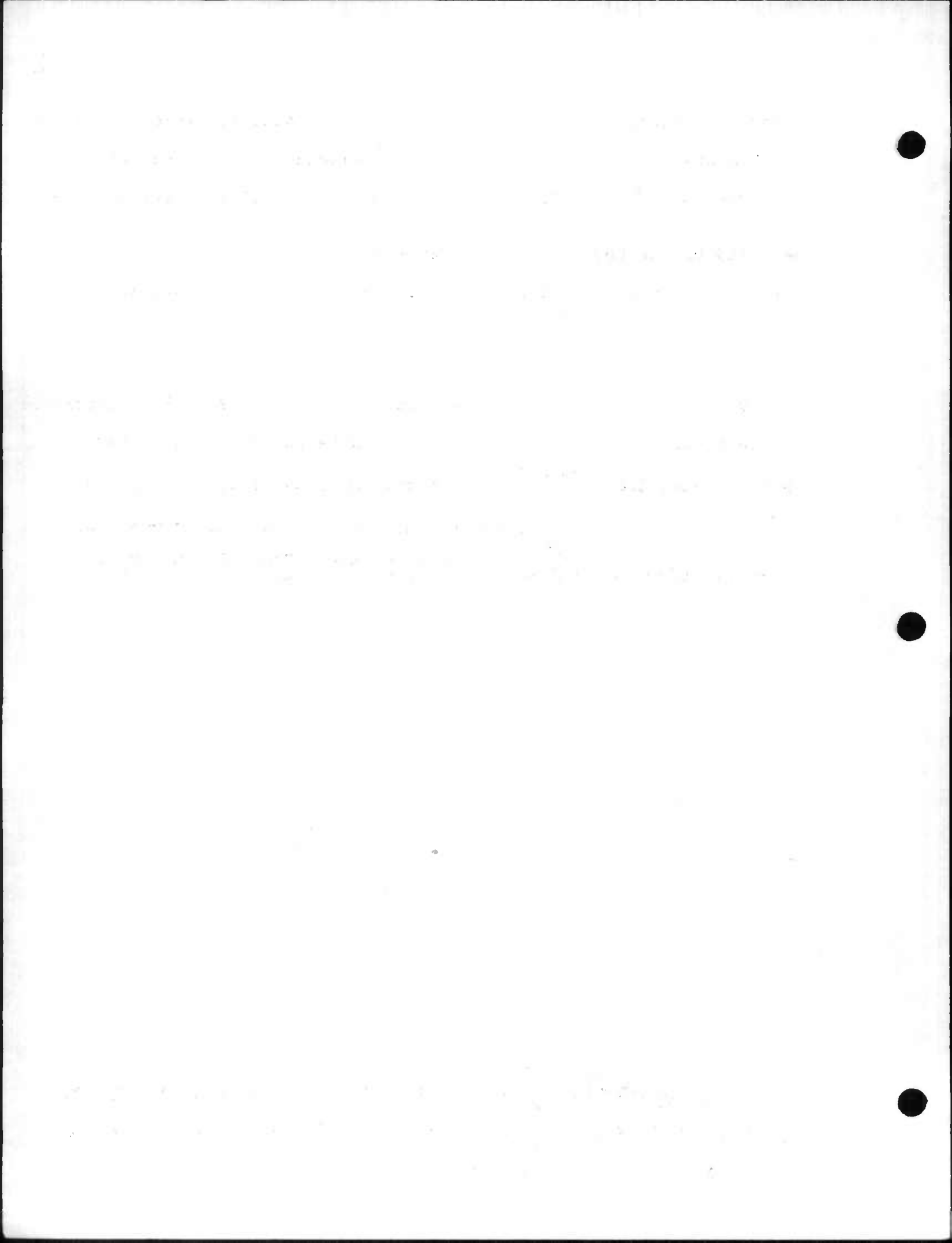
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





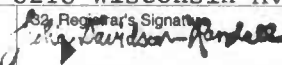
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25543

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Anna Marie Edwards-Harris</b>				2. Date of Death Month Day Year <b>August 14, 1996</b>		3. Time of Death <b>10:05 am</b>	
	4a. Facility Name (If not institution, give street and number) <b>12807 Caldwell Street</b>				4b. City, Town, or Location of Death <b>Rockville</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>525-64-2176</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>85</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan. 13, 1911</b>	
	9. Birthplace (State or Foreign Country) <b>Illinois</b>		10e. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Rockville</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>12807 Caldwell Street</b>		10f. Zip Code <b>20853</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>			
	17. Father's Name (First, Middle, Last) <b>Michael Reardon</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Emma Stauffer</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Kenneth R. Edwards/Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12807 Caldwell Street, Rockville, Maryland 20853</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery</b>		20c. Location - City or Town, State <b>Silver Spring, Maryland</b>		20d. Date <b>Aug. 17, 1996</b>	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850</b>		22. M00335			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Cardiac arrhythmia</b> Due to (or as a consequence of): <b>chronic obstructive pulmonary disease</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>years</b>				Approximate Interval Between Onset and Death <b>6 mos</b>			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accidental <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal		26a. Date of Injury (Month, Day Year)		26b. Time of Injury <b>M</b>		26c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
26d. Describe how injury occurred		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D08546</b>		29d. Date signed (Month, Day, Year) <b>August 14, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John F. Tauber M.D. 8218 Wisconsin Avenue #318, Bethesda, Maryland 20814-3107</b>								
31. Date filed (Month, Day, Year) <b>AUG 16 1996</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25544

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Oliver Allen Freeman</b>				2. Date of Death Month <b>August</b> Day <b>13</b> Year <b>1996</b>		3. Time of Death <b>8:00 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Memorial Hospital at Easton</b>				4b. City, Town, or Location of Death <b>Easton</b>		4c. County of Death <b>Talbot</b>		
Funeral Director	5. Social Security Number <b>218-34-3120</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>58</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Apr. 16, 1938</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Talbot</b>		10c. City, Town or Location <b>Trappe</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number <b>3797 So. Main Street</b>				10f. Zip Code <b>21673</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>10th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Sanitation</b>		16b. Kind of Business/Industry <b>Town Of Easton</b>				
	17. Father's Name (First, Middle, Last) <b>Frisby Freeman</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Margaret Young</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Patricia Lee Freeman</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3797 So. Main Street, Trappe, Md. 21673</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Paradise Cemetery</b>		Date <b>8/17/96</b>		20c. Location - City or Town, State <b>Trappe, Md.</b>		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Bennie Smith Funeral Home P.O. Box 1687, Easton, Md. 21601</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>LUNG Cancer</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death <b>3 mo</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
			28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	29b. Signature and title of certifier 				29c. License number <b>D 01225</b>		29d. Date signed (Month, Day, Year) <b>8-13-96</b>		
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Stephen P. Carney, MD, 509 Idlewild Ave, Easton, Md. 21601</b>								
	31. Date filed (Month, Day, Year) <b>AUG 14 1996</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25545

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Catherine Irene Follin</i>				2. Date of Death Month <i>July</i> Day <i>25</i> Year <i>1996</i>		3. Time of Death <i>11:00 AM</i>												
	4a. Facility Name (If not institution, give street and number) <i>Washington County Hospital</i>				4b. City, Town, or Location of Death <i>Hagerstown</i>		4c. County of Death <i>Washington</i>												
Funeral Director	5. Social Security Number <i>220-26-6822</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>80</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>Dec. 3, 1915</i>												
	9. Birthplace (State or Foreign Country) <i>Virginia</i>		10a. State <i>Maryland</i>		10b. County <i>Washington</i>		10c. City, Town or Location <i>Hagerstown</i>												
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No														
	10e. Street and Number <i>355 Antietam Drive</i>				10f. Zip Code <i>21742</i>		10g. Citizen of What Country? <i>U.S.A.</i>												
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>												
	15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i> <i>12</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i>		16b. Kind of Business/Industry <i>None</i>														
	17. Father's Name (First, Middle, Last) <i>Arthur Franklin Sine</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Emma Catherine Romick</i>														
	19a. Informant's Name/Relationship (Type, Print) <i>Joan M. Follin/Daughter</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1262 Calvert Beach Rd., St. Leonard, MD 20285</i>														
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Parklawn Memorial Gardens</i>		20c. Location - City or Town, State <i>Rockville, Maryland</i>														
	21. Signature of Funeral Service Licensee <i>Robert E. Dailey</i>		22. Name and Address of Facility <i>ROBERT E. DAILEY &amp; SON FUNERAL HOMES, P.A. 615 EAST MAIN STREET, THURMONT, MD 21788</i>																
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																		
	<table border="0"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td><i>Respiratory insufficiency</i></td> <td>Approximate Interval Between Onset and Death <i>8 day</i></td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td><i>Peritonitis</i></td> <td><i>10 day</i></td> </tr> <tr> <td><i>Perforated Sigmoid colon</i></td> <td><i>10 day</i></td> </tr> <tr> <td></td> <td></td> </tr> <tr> <td></td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	<i>Respiratory insufficiency</i>	Approximate Interval Between Onset and Death <i>8 day</i>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<i>Peritonitis</i>	<i>10 day</i>	<i>Perforated Sigmoid colon</i>	<i>10 day</i>			
Immediate Cause (Final disease or condition resulting in death)	<i>Respiratory insufficiency</i>	Approximate Interval Between Onset and Death <i>8 day</i>																	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<i>Peritonitis</i>	<i>10 day</i>																	
	<i>Perforated Sigmoid colon</i>	<i>10 day</i>																	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes Mellitus</i>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown													
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred															
28f. Location (Street and Number or Rural Route Number, City or Town, State)																			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Max Gross</i>		29c. License number <i>00050337</i>		29d. Date signed (Month, Day, Year) <i>7/25/96</i>													
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Max Gross 1110 Med. Campus Rd Hagerstown MD</i>																			
31. Date filed (Month, Day, Year) <i>JUL 30 1996</i>		32. Registrar's Signature <i>John Anderson-Randall</i>																	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25546

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Helen P. Flora

2. Date of Death

Month August Day 10, 1996 Year

3. Time of Death

2:35P.

4a. Facility Name (If not institution, give street and number)

Mariner Health CARE of Greater Laurel

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

219-12-4197

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 20, 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Beltsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4905 Wicomico Avenue

10f. Zip Code

20705

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Harry A. Pilkerton

18. Mother's Name (First, Middle, Maiden Surname)

Rena P. Owens

19a. Informant's Name/Relationship (Type, Print)

Franklin A. Pilkerton (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

RR1 Box H-3 Madison, Virginia 22727

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery 8/13/1996

Date

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

Donald V. Borgwardt

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.  
4400 Powder Mill Rd. Beltsville, Maryland 20705

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Cancer of the Breast  
Due to (or as a consequence of):  
b. will metastasize  
Due to (or as a consequence of):  
c.  
Due to (or as a consequence of):  
d.

Approximate Interval Between Onset and Death

2 years

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Syed Sadiq, M.D.

29c. License number

24721

29d. Date signed (Month, Day, Year)

August 12, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Syed Sadiq, M.D. 14800 4th Street, #11A Laurel, Maryland 20707-3708

31. Date filed (Month, Day, Year)

AUG 14 1996

32. Registrar's Signature

John Davidson

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25547

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Hazel H. Gochenour</b>		2. Date of Death Month <b>August</b> Day <b>18</b> Year <b>1996</b>		3. Time of Death <b>6:30 A.M.</b>
	4a. Facility Name (If not institution, give street and number) <b>Homecove Nursing Facility</b>		4b. City, Town, or Location of Death <b>Laytonsville</b>		4c. County of Death <b>Montgomery</b>
Funeral Director	5. Social Security Number <b>454-03-2823</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>87</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>February 22, 1909</b>		9. Birthplace (State or Foreign Country) <b>Texas</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State <b>MD</b>		10b. County <b>Montgomery</b>
	10c. City, Town or Location <b>Ashton</b>		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number <b>17234 New Hampshire Avenue</b>		10f. Zip Code <b>20861</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status 1 <input type="checkbox"/> Navar Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4 or 5+) <b>3</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>
	16b. Kind of Business/Industry <b>Own Home</b>		17. Father's Name (First, Middle, Last) <b>Charles Lowry Hudgens</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Linnie Bell Hunter</b>
	19a. Informant's Name/Relationship (Type, Print) <b>Gail G. Rust (Daughter)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6 Kaywood Court, Silver Spring, Maryland 20905</b>		
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mount Comfort Crematory</b>		20c. Location - City or Town, State <b>8/21/96 Alexandria, VA</b>
	21. Signature of Funeral Service Licensee <i>Sum Titomus Bank</i>		22. Name and Address of Facility <b>Affordable Funeral Services 7400 Lee Highway, Falls Church, VA 22042</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Alzheimer's Dementia</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>3 Years</b>		Approximate Interval Between Onset and Death <b>3 Years</b>		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>M</b>		28b. Time of Injury <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>James Michael Anchors</i>		29c. License number <b>D29730</b>	
29d. Date signed (Month, Day, Year) <b>August 19, 1996</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>James Michael Anchors, M.D. 16220 Frederick Road #210 Gaithersburg, MD 20877</b>			
31. Date filed (Month, Day, Year) <b>AUG 27 1996</b>		32. Registrar's Signature <i>John [Signature]</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25548

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARY KATHRYN GEIB			2. Date of Death Month 08 Day 15 Year 96			3. Time of Death 08:00 AM			
	4a. Facility Name (If not institution, give street and number) Caroline Nursing Home, Inc.			4b. City, Town, or Location of Death Denton, Maryland			4c. County of Death Caroline			
Funeral Director	5. Social Security Number 220-28-4817			6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F			7. Age (In yrs. last birthday) 84 Yrs.			
	8. Date of Birth (Month, Day, Year) JUNE 13, 1912			9. Birthplace (State or Foreign Country) MARYLAND						
To Be Completed by Funeral Director	Usual Residence of Decedent									
	10a. State MD			10b. County TALBOT			10c. City, Town or Location EASTON			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	10e. Street and Number 7 CRAB APPLE COURT			10f. Zip Code 21601			10g. Citizen of What Country? USA			
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 3			16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TEACHER			18b. Kind of Business/Industry PUBLIC EDUCATION			
	17. Father's Name (First, Middle, Last) DAVID R. GEIB			18. Mother's Name (First, Middle, Maiden Surname) HELEN MILBY						
	19a. Informant's Name/Relationship (Type, Print) DANIEL F. GEIB/NEPHEW			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31895 COVEY'S LANDING RD., CORDOVA, MD						
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) FAIRVIEW CHURCH CEM.			20c. Location - City or Town, State CORDOVA, MD			
	21. Signature of Funeral Service Licensee M. E. Newman III CFSP			22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 200 S. HARRISON ST., EASTON, MD 21601						
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Parkinson's Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28e. Date of Injury (Month, Day, Year)			28b. Time of injury M			28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier James Sides MD			29c. License number D 3137C			29d. Date signed (Month, Day, Year) 8-15-96				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James Sides 920 Market St Denton MD										
31. Date filed (Month, Day, Year) AUG 16 1996			32. Registrar's Signature Julia Davidson-Randall							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

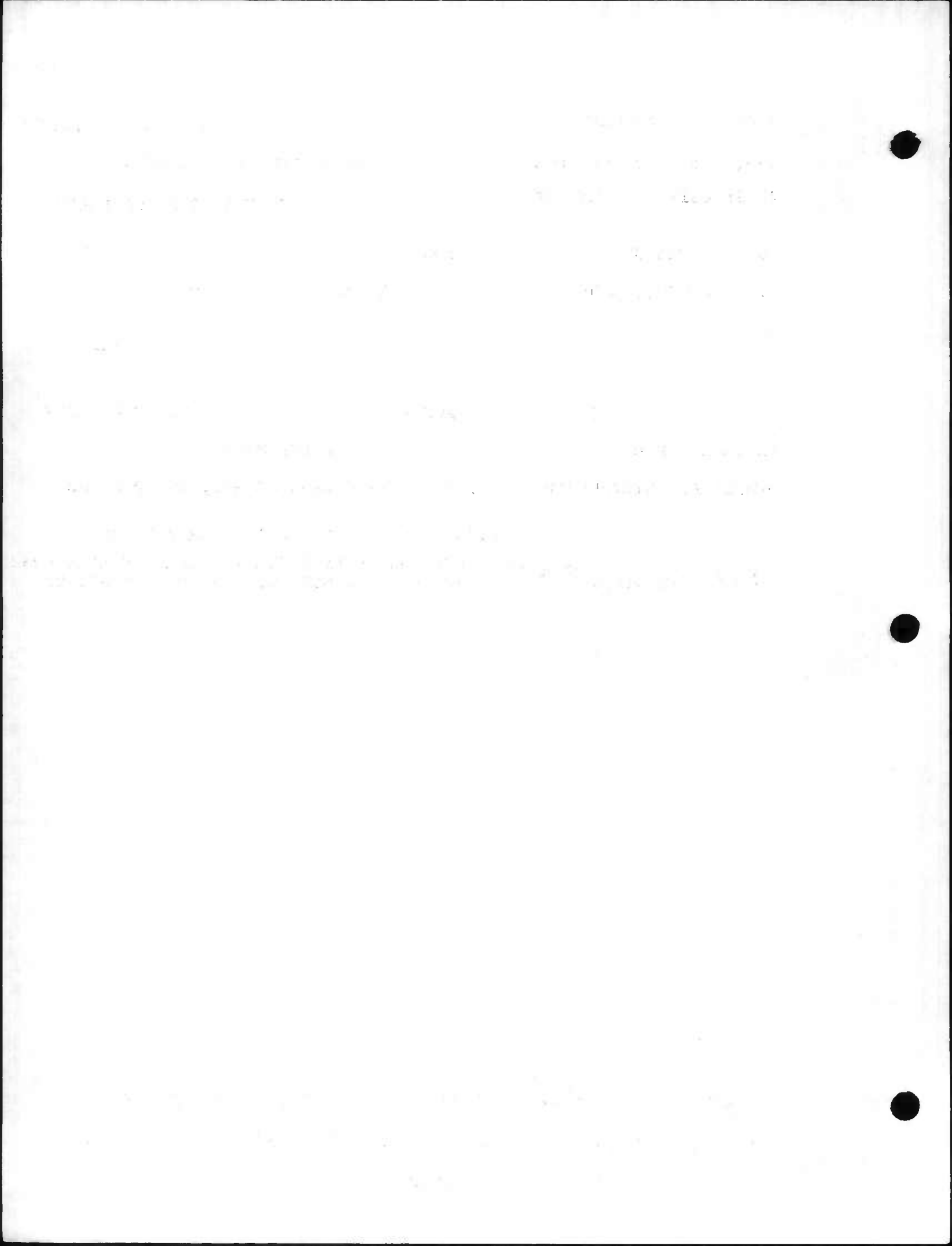
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25549

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JANE NMN GRUNDTVIG</b>				2. Date of Death Month: <b>08</b> Day: <b>05</b> Year: <b>96</b>		3. Time of Death <b>935 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>UMMS</b>				4b. City, Town, or Location of Death <b>Baltimore md</b>		4c. County of Death <b>Baltimore City</b>	
Funeral Director	5. Social Security Number <b>547-40-5413</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>72</b> Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min:	8. Date of Birth (Month, Day, Year) <b>Nov. 28, 1923</b>		9. Birthplace (State or Foreign Country) <b>California</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>none</b>	10b. County <b>none</b>	10c. City, Town or Location <b>Washington, D.C.</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>1619 Webster Street, N.W.</b>			10f. Zip Code <b>20011</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>sales clerk</b>		16b. Kind of Business/Industry <b>department store</b>			
	17. Father's Name (First, Middle, Last) <b>unavailable</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>unavailable</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Frank B. Conlon / friend</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2032 Belmont Rd., #610, Washington, DC 20009</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery</b>		20c. Location - City or Town, State <b>Silver Spring, Md.</b>			
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>DeVol Funeral Home</b> <b>2222 Wisconsin Ave., N.W., Washington, D.C. 20007</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) e. <b>neurotizing fascitis</b> Due to (or as a consequence of): b. <b>streptococcal infection</b> Due to (or as a consequence of): c. <b>DIC</b> Due to (or as a consequence of): d.							<b>days</b> <b>days</b> <b>days</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>infarcted spleen, colectomy, colostomy</b> <b>rephrectomy, wound debridement</b>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Kevin B Gerold MD</b>		29c. License number <b>H31298</b>		29d. Date signed (Month, Day, Year) <b>08/06/96</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>KEVIN B GEROLD, 22 S GREENE ST, BALTIMORE, MD 21201</b>								
31. Date filed (Month, Day, Year) <b>AUG 14 1996</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that proper record-keeping is essential for the integrity of the financial system and for the ability to detect and prevent fraud.

2. The second part of the document outlines the specific procedures for recording transactions. It details the steps involved in the accounting process, from the initial entry of data into the system to the final review and approval of the records.

3. The third part of the document addresses the challenges associated with maintaining accurate records. It identifies common sources of error and provides strategies for minimizing these errors, such as implementing strict controls and regular audits.

4. The fourth part of the document discusses the role of technology in improving record-keeping. It highlights the benefits of using automated systems to process transactions and generate reports, while also noting the need for proper training and oversight to ensure the reliability of these systems.

5. The fifth part of the document concludes by emphasizing the ongoing nature of the record-keeping process. It stresses that records must be continuously updated and maintained to reflect the current state of the organization's financial affairs.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 25550

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Aillean Jean Gerhold</b>				2. Date of Death Month <b>August</b> Day <b>8</b> , Year <b>1996</b>		3. Time of Death <b>12:28 pm</b>	
	4e. Facility Name (If not institution, give street and number) <b>Suburban Hospital</b>				4b. City, Town, or Location of Death <b>Bethesda</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>312-18-2429</b>		6. Sex <b>1</b> M <b>2</b> F	7. Age (In yrs. last birthday) <b>70</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept. 18, 1925</b>	
	9. Birthplace (State or Foreign Country) <b>Indiana</b>							
To Be Completed by Funeral Director	10e. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Wheaton</b>		10d. Inside City Limits <b>1</b> Yes <b>2</b> No	
	10e. Street and Number <b>1802 Belvedere Boulevard</b>				10f. Zip Code <b>20902</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Executive Secretary</b>		16b. Kind of Business/Industry <b>Beverage</b>			
	17. Father's Name (First, Middle, Last) <b>Carl L. Clark</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Evelyn Weingarden</b>			
To Be Completed by Physician/Medical Examiner	19e. Informant's Name/Relationship (Type, Print) <b>David Clark</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 445, Portage, Indiana 46368</b>			
	20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery</b>		Date <b>8/12/96</b>		20c. Location - City or Town, State <b>Silver Spring, Maryland</b>	
	21. Signature of Funeral Service Licensee <i>William L. Byrd</i>		22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901</b>					
	23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <b>CARDIOMYOPATHY</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death <b>1 yr</b>							
	Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Excessive Alcohol use</b>						23b. Did tobacco use contribute to the causa of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown		
24e. Was an autopsy performed? <b>1</b> Yes <b>2</b> No		24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No						
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No		26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)						
27. Manner of Death <b>1</b> Natural <b>5</b> Pending investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred						
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Richard H. Pollen MD</i>		29c. License number <b>D09577</b>		29d. Date signed (Month, Day, Year) <b>8-9-96</b>				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>RICHARD H. POLLEN MD 10400 CONNECTICUT AV KENSINGTON MD 20895</b>								
31. Date filed (Month, Day, Year) <b>AUG 12 1996</b>		32. Registrar's Signature <i>John Davidson-Randall</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

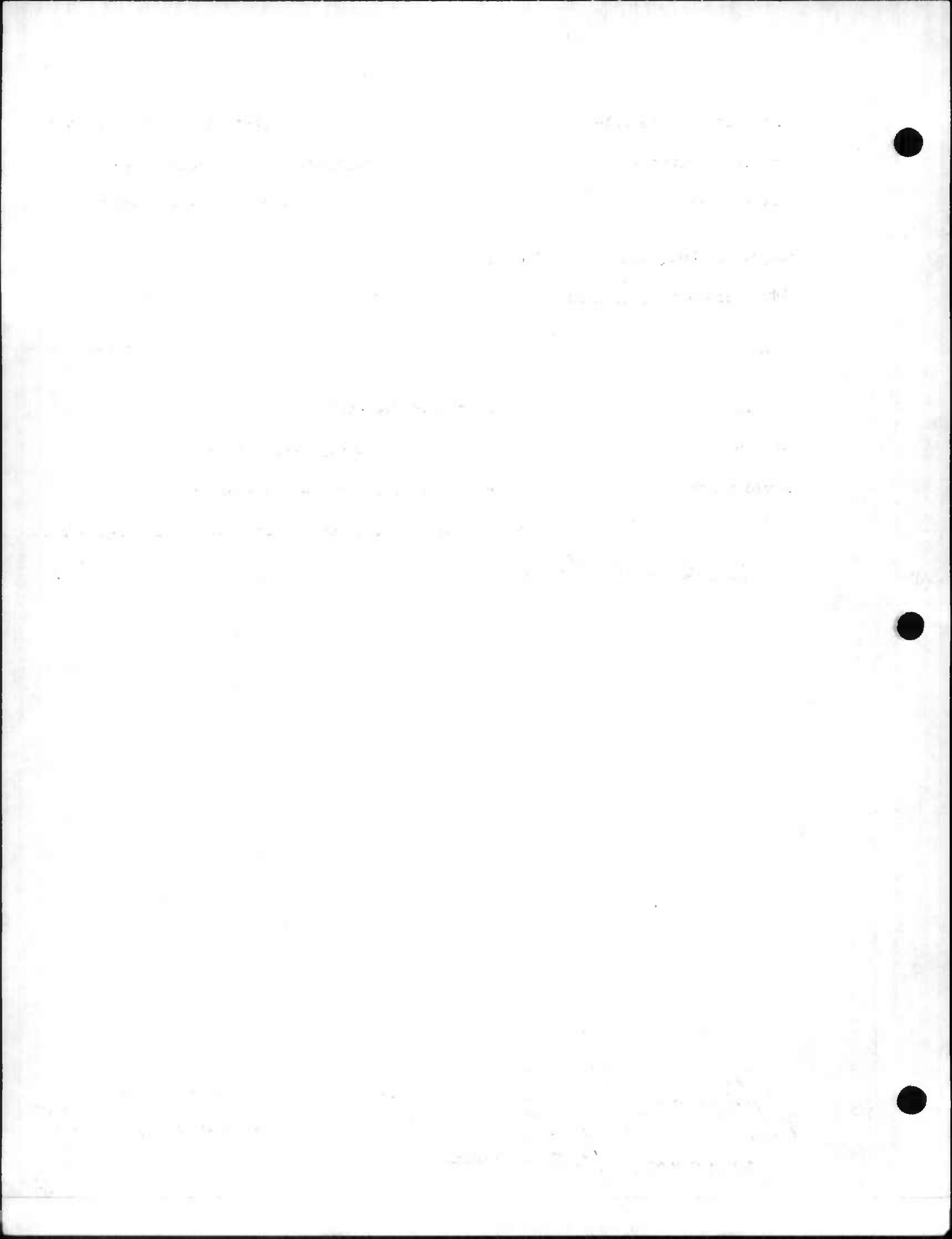
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

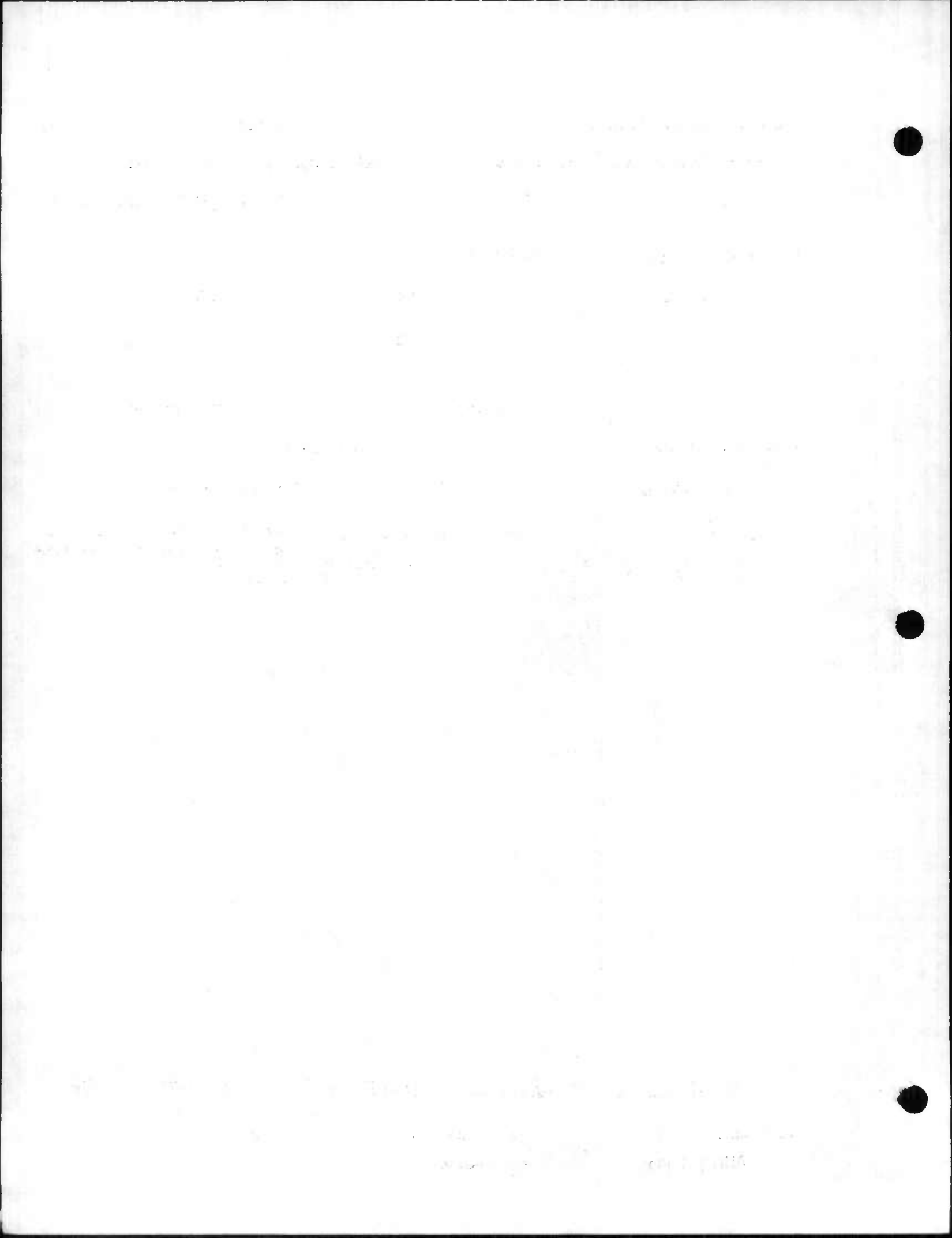
Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



DHHM 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25552

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lucy Gilson

2. Date of Death

Month Day Year  
August 6 1996

3. Time of Death

5:30 PM

4a. Facility Name (If not institution, give street and number)

Greater Laurel Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

216-44-3210

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

(Month, Day, Year)  
Oct. 24, 1905

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14200 Laurel Park Drive

10f. Zip Code

20707

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

James A. Beall

18. Mother's Name (First, Middle, Maiden Surname)

Rosa M. Harper

19a. Informant's Name/Relationship (Type, Print)

Mary L. Fahey

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4415 49th Street, NW, Washington DC 20016

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
crematory, crematory or other place)

Metropolitan Crematory

Date

8/8/96

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Timothy J. Campbell

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc. 500 University Blvd. West  
Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Sepsis  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

1 week

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Pneumonia  
Due to (or as a consequence of):

1 week

c. Dementia  
Due to (or as a consequence of):

5 years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

Inpatient

2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Paul Davidson-Randall

29c. License number

043237

29d. Date signed (Month, Day, Year)

8-7-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14201 Laurel Pk. Dr. #102 Laurel MD 20707

31. Date filed (Month, Day, Year)

AUG 08 1996

32. Registrar's Signature

Paul Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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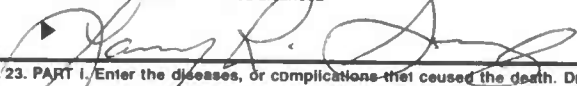

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>RICHARD ALBERT HOIBBS</b>						2. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 12 1996</b>		3. TIME OF DEATH <b>9:30A.</b>		
4. SOCIAL SECURITY NUMBER <b>219-34-5497</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>60</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov. 25, 1935</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>11 Mountainview Place</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>Thurmont</b>		9c. COUNTY OF DEATH <b>Frederick</b>		
RESIDENCE OF DECEDENT										
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Frederick</b>		10c. CITY, TOWN OR LOCATION <b>Thurmont</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER <b>11 Mountainview Place</b>				10f. ZIP CODE <b>21788</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1962</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Planner</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Moores Business Forms</b>				
17. FATHER'S NAME (First, Middle, Last) <b>Charles Bernard Hobbs</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ruth Helen Buhrman</b>				
19a. INFORMANT'S NAME (Type/Print) <b>Carol Walker Hobbs, wife</b>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11 Mountainview Place Thurmont, Maryland 21788</b>				
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Blue Ridge Cemetery</b>		DATE <b>8/15/96</b>		20c. LOCATION — City or Town, State <b>Thurmont, Maryland</b>				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 						22. NAME AND ADDRESS OF FACILITY <b>Stauffer Funeral Homes, P.A. 104 East Main Street Thurmont, MD 21788</b>				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. GUN SHOT - HEAD</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST									Approximate Interval Between Onset and Death <b>SECONDS</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSION, RENAL FAILURE, DEPRESSION</b>									24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>8 12 96</b>		28b. TIME OF INJURY <b>— M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <b>SHOT SELF IN HEAD</b>		
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>HOME</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>11 MOUNTAINVIEW RD THURMONT MD 21788</b>						
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Robert R. Roberts MD</b>						29c. LICENSE NUMBER <b>D09867</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/12/96</b>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>7501 B Mc KAIG ROAD FREDERICK MD 21701-3319 RRRROBERTS</b>										
31. DATE FILED (Month, Day, Year) <b>AUG 14 1996</b>		32. REGISTRAR'S SIGNATURE 								

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25554

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DENISE ALICE HEILMANN</b>				2. Date of Death Month <b>JULY</b> Day <b>31</b> Year <b>1996</b>		3. Time of Death <b>0420</b>							
	4a. Facility Name (If not Institution, give street and number) <b>SUBURBAN HOSPITAL</b>				4b. City, Town, or Location of Death <b>BETHESDA</b>		4c. County of Death <b>MONTGOMERY</b>							
Funeral Director	5. Social Security Number <b>579-42-3744</b>		8. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>70</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>February 18, 1926</b>		9. Birthplace (State or Foreign Country) <b>Paris, France</b>					
	Usual Residence of Decedent													
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Wheaton</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
10e. Street and Number <b>12104 Livingston Street</b>				10f. Zip Code <b>20902</b>		10g. Citizen of What Country? <b>U.S.A.</b>								
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>						
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> Collage (1-4 or 5+) <b>4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Teacher</b>			16b. Kind of Business/Industry <b>Education</b>							
17. Father's Name (First, Middle, Last) <b>Henri Martin</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Marie Louise Chaume</b>									
19a. Informant's Name/Relationship (Type, Print) <b>Joseph Heilmann-Husband</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12104 Livingston Street, Wheaton, MD 20902</b>									
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>George Washington University Medical Center</b>			Date <b>July 31, 1996</b>		20c. Location - City or Town, State <b>Washington, DC</b>						
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Columbia Mortuary Services, Inc. 225 Missouri Ave., NW, Washington, DC 20011</b>											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>BREAST CANCER</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>ACUTE RENAL FAILURE</b> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):										Approximate Interval Between Onset and Death <b>10 yrs</b>				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ACUTE RENAL FAILURE</b>										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner			29b. Signature and title of certifier M.D.								29c. License number <b>D20674</b>		29d. Date signed (Month, Day, Year) <b>July 31, 1996</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Stephen Hellman M.D. 6240 Montrose Rd Rockville MD 20852</b>														
31. Date filed (Month, Day, Year) <b>AUG 14 1996</b>			32. Registrar's Signature 											

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



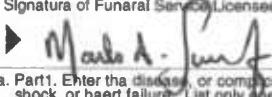

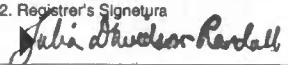
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25555

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ERMA ZERELDA HARMON</b>			2. Date of Death Month <b>August</b> Day <b>12</b> Year <b>1996</b>			3. Time of Death <b>3:24 a.m.</b>			
	4e. Facility Name (If not institution, give street and number) <b>William Hill Health Care Center</b>			4b. City, Town, or Location of Death <b>Cambridge</b>			4c. County of Death <b>Dorchester</b>			
Funeral Director	5. Social Security Number <b>213-18-7447</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>80</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Dec 22, 1915</b>	9. Birthplace (State or Foreign Country) <b>MD</b>			
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>Dorchester</b>	10c. City, Town or Location <b>Cambridge</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number <b>125 Maryland Ave.</b>			10f. Zip Code <b>21613</b>			10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Worker</b>			16b. Kind of Business/Industry <b>Shoe Company</b>			
	17. Father's Name (First, Middle, Last) <b>Charles Joseph Sykes</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Bessie Walsh</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Grand-Harold T. Flater, son</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>707 Beauchamp St. Salisbury, Md. 21801</b>						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Westminster Cemetery</b>			Data <b>8/15/96</b>		20c. Location - City or Town, State <b>Westminster, Md</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Pritts Funeral Home 412 Washington Road Westminster, Md 21157</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Cerebrovascular Accident</b> Due to (or as a consequence of): b. <b>ASCVD</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death <b>4 hrs</b> <b>5 hrs</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Atherosclerotic Cardiovascular Disease</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 				29c. License number <b>D26388</b>			29d. Date signed (Month, Day, Year) <b>8-12-96</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Michael Fadden MD 302 Collins, Huelock Md 21643</b>										
31. Date filed (Month, Day, Year) <b>AUG 15 1996</b>			32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25556

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>VIVIAN L. HAYES</b>				2. Date of Death Month <b>Aug.</b> Day <b>12</b> Year <b>1996</b>		3. Time of Death <b>5:07A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Allegis of Southern Maryland</b>				4b. City, Town, or Location of Death <b>Clinton</b>		4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>578-44-5864</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>79</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec. 13, 1916</b>	
	9. Birthplace (State or Foreign Country) <b>Washington, D.C.</b>		10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Clinton</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>9211 Stuart Lane</b>		10f. Zip Code <b>20735</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>3</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Teacher's Aide</b>		16b. Kind of Business/Industry <b>D.C. Public Schools</b>			
	17. Father's Name (First, Middle, Last) <b>William Carson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Marie Bennett</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Julie Saunders</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7101 Goblet Way, Clinton, Maryland 20735</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Olivet Cemetery</b>		20c. Date <b>8/16/96</b>		20d. Location - City or Town, State <b>Washington, D.C.</b>	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>McGuire Funeral Service Inc. 7400 Georgia Ave., N.W., Wash., D.C. 20012</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>CHF</b> Due to (or as a consequence of): b. <b>Pneumonia</b> Due to (or as a consequence of): c. <b>Renal failure</b> Due to (or as a consequence of): d. <b>DM</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <i>[Signature]</i> <b>A. L. Attence, MD</b>		29c. License number <b>D24208</b>		29d. Date signed (Month, Day, Year) <b>8-15-96</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ABUL HASAN U ANSARI 8926 Woodyard Rd #101 Clinton Md. 20735</b>							
	31. Date filed (Month, Day, Year) <b>AUG 16 1996</b>		32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25557

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Phyllis Beatrice Hagberg</b>						2. Date of Death Month Day Year <b>August 11, 1996</b>		3. Time of Death <b>12:45am</b>		
	4a. Facility Name (If not Institution, give street and number) <b>Allegis Nursing Home</b>						4b. City, Town, or Location of Death <b>Kensington</b>		4c. County of Death <b>Montgomery</b>		
Funeral Director	5. Social Security Number <b>214-28-7710</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>90</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		
	8. Date of Birth (Month, Day, Year) <b>June 21, 1906</b>		9. Birthplace (State or Foreign Country) <b>New York</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>		
To Be Completed by Funeral Director	10e. Street and Number <b>9908 Cherry Tree Lane</b>		10f. Zip Code <b>20901</b>		10g. Citizen of What Country? <b>USA</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>						
	17. Father's Name (First, Middle, Last) <b>Thomas A. Young</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Theresa Lagerdahl</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>Robert Hagberg</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4708 Boiling Brook Parkway, Rockville, MD 20852</b>						
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Sunset Hill Cemetery</b>		Date <b>8/17/96</b>		20c. Location - City or Town, State <b>Jamestown, NY</b>				
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Francis J. Collins Funeral Home Inc. 500 University Blvd. West Silver Spring, MD 20901</b>						
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death		
	a. <b>Dehydration and Azotemia</b> Due to (or as a consequence of): b. <b>Chronic Renal Insufficiency</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.								<b>2 Weeks</b>    <b>2 Years</b>		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>DO6674</b>		29d. Date signed (Month, Day, Year) <b>8/12/96</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Myron Lenkin, M.D. 2309 Shorefield Road, Wheaton, MD 20907</b>											
31. Date filed (Month, Day, Year) <b>AUG 14 1996</b>		32. Registrar's Signature 									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indellible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25558

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HARRY GLENNYS HANSON</b>				2. Date of Death Month Day Year <b>AUGUST 14 1996</b>				3. Time of Death <b>12:25 AM</b>				
	4e. Facility Name (If not institution, give street and number) <b>NATIONAL NAVAL MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>BETHESDA</b>				4c. County of Death <b>MONTGOMERY</b>				
Funeral Director	5. Social Security Number <b>284-36-1539</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) <b>86</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Nov. 26, 1909</b>		9. Birthplace (State or Foreign Country) <b>Minnesota</b>				
	Usual Residence of Decedent												
10a. State		10b. County		10c. City, Town or Location <b>Washington, D.C.</b>						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number <b>2801 New Mexico Avenue, N.W.</b>				10f. Zip Code <b>20007</b>				10g. Citizen of What Country? <b>United States</b>					
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1942-1966</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>5+</b>				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Environmental Engineer</b>				16b. Kind of Business/Industry <b>U.S. Government</b>					
17. Father's Name (First, Middle, Last) <b>Edward Thron Hanson</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Agnetha Backlund</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Yolanda G. Hanson/wife</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2801 New Mexico Avenue, N.W., Washington, D.C. 20007</b>								
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gettysburg National Cemetery</b>			20c. Location - City or Town, State <b>Gettysburg, Pennsylvania</b>		20d. Date <b>August 16, 1996</b>				
21. Signature of Funeral Service Licensee <b>David E. Perry</b> M00803				22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501</b>									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. PNEUMONIA</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>										Approximate Interval Between Onset and Death <b>DAYS</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>T.W. Schaffer MD</b>				29c. License number <b>D-467810</b>		29d. Date signed (Month, Day, Year) <b>AUG 14, 1996</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>T.W. SCHAFER, LT, MC, USN</b> <b>NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600</b>													
31. Date filed (Month, Day, Year) <b>AUG 16 1996</b>										32. Registrar's Signature <b>[Signature]</b>			

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25559

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Byrne Hopkins				2. Date of Death Month Day Year August 08, 1996				3. Time of Death 10:07 A.M.	
	4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL				4b. City, Town, or Location of Death ROCKVILLE				4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 196-03-3273		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) Jan. 2, 1911		9. Birthplace (State or Foreign Country) Pennsylvania		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Gaithersburg	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 120 Gold Kettle Drive		10f. Zip Code 20878		10g. Citizen of What Country? United States		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary	
	16b. Kind of Business/Industry Federal Government		17. Father's Name (First, Middle, Last) William Byrne		18. Mother's Name (First, Middle, Maiden Surname) Christina Imhoff		19a. Informant's Name/Relationship (Type, Print) Frank J. Hopkins/Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 120 Gold Kettle Drive, Gaithersburg, MD. 20877	
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State 8/8/96 Alexandria, Virginia		21. Signature of Funeral Service Licensee Michael A. Gelber		22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877	
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial Infarct Due to (or as a consequence of): b. Atherosclerotic Heart Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death Minutes YEARS		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Gary W. Langston, M.D.	
	29c. License number D 17947		29d. Date signed (Month, Day, Year) August 8, 1996		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) GARY W. LANGSTON 9901 MEDICAL CENTER DRIVE		31. Date filed (Month, Day, Year) AUG 12 1996		32. Registrar's Signature Davidson-Randall	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

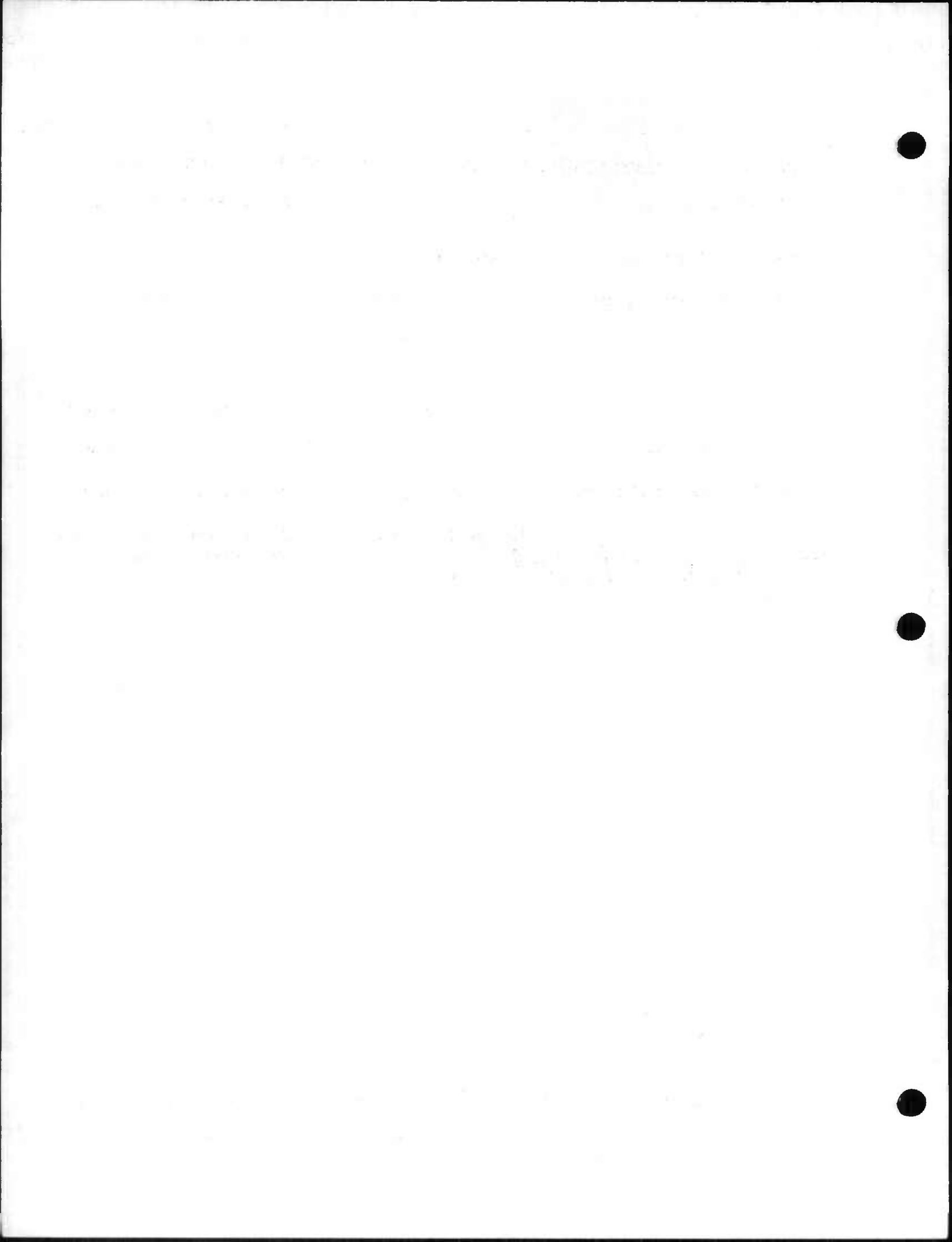
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar




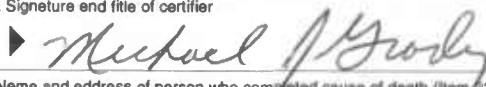
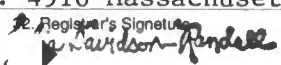
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25560

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Stefan Ferdinand Horn</b>						2. Date of Death Month <b>August</b> Day <b>9</b> Year <b>1996</b>		3. Time of Death <b>11:15 pm</b>									
	4a. Facility Name (If not institution, give street and number) <b>4952 Sentinel Drive #202</b>						4b. City, Town, or Location of Death <b>Bethesda</b>		4c. County of Death <b>Montgomery</b>									
Funeral Director	5. Social Security Number <b>106-24-4935</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>96</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan. 4, 1900</b>		9. Birthplace (State or Foreign Country) <b>Austria</b>									
	Usual Residence of Decedent																	
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Bethesda</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
	10e. Street and Number <b>4952 Sentinel Drive #202</b>				10f. Zip Code <b>20816</b>		10g. Citizen of What Country? <b>United States</b>											
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>										
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4or 5+) <b>5+</b>			16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Educator</b>			16b. Kind of Business/Industry <b>Education</b>											
	17. Father's Name (First, Middle, Last) <b>Paul Horn</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Risa Strissower</b>											
To Be Completed by Physician/Medical Examiner	19e. Informant's Name/Relationship (Type, Print) <b>Nancy A. Horn/ Wife</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4952 Sentinel Drive #202 Bethesda, Maryland 20816</b>											
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Montgomery Crematorium Inc.</b>			Date <b>August 11, 1996</b>		20c. Location - City or Town, State <b>Bethesda, Maryland</b>									
	21. Signature of Funeral Service Licensee  <b>M00335</b>						22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501</b>											
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																	
	<table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>e. <b>C H F</b></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>b. <b>Arteriosclerotic Vascular Disease</b></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	e. <b>C H F</b>	Due to (or as a consequence of):	b. <b>Arteriosclerotic Vascular Disease</b>	Due to (or as a consequence of):	c.	Due to (or as a consequence of):	d.
Immediate Cause (Final disease or condition resulting in death)	e. <b>C H F</b>	Due to (or as a consequence of):																
	b. <b>Arteriosclerotic Vascular Disease</b>	Due to (or as a consequence of):																
	c.	Due to (or as a consequence of):																
	d.	Due to (or as a consequence of):																
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Mellitus</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28e. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred									
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier 		29c. License number <b>D38781</b>		29d. Date signed (Month, Day, Year) <b>August 10, 1996</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Michael J. Grady, M.D. 4910 Massachusetts Avenue N.W. #312, Washington D.C. 20016</b>																		
31. Date filed (Month, Day, Year) <b>AUG 12 1996</b>			32. Registrar's Signature 															

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25561

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ralph

Hill

2. Date of Death

Month Day Year  
August 7, 1996

3. Time of Death

3:15 PM

4a. Facility Name (If not institution, give street and number)

1220 Blair Mill Road, #908

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

135-42-2942

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

45 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 17, 1951

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1220 Blair Mill Road, #908

10f. Zip Code

20910

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Customer Service Representative

16b. Kind of Business/Industry

Telephone Company

17. Father's Name (First, Middle, Last)

Benjamin Franklin Hill

18. Mother's Name (First, Middle, Maiden Surname)

Corine Traynum

19a. Informant's Name/Relationship (Type, Print)

Benjamin F. Hill, Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10 Oak Street, Jersey City, NJ 07304

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Heavenly Rest Memorial Park

Date

8-12-96

20c. Location - City or Town, State

Jersey City, New Jersey

21. Signature of Funeral Service Licensee

Ellen H. Rapp

22. Name and Address of Facility

Rapp Funeral Services, P. A.  
933 Gist Avenue, Silver Spring, MD 2091023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. End Stage AIDS

Due to (or as a consequence of):

b. Hepatitis B and Cachexia

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 8 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Felix Sokolsky

29c. License number

D 46364

29d. Date signed (Month, Day, Year)

August 9, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Felix Sokolsky, M. D., 8401 Colesville Road, Silver Spring, MD 20910

State  
Registrar

31. Date filed (Month, Day, Year)

AUG 12 1996

32. Registrar's Signature

Felix Davidson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25562

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Homer Edward Hannon

2. Date of Death

August 12, 1996

3. Time of Death

9:45 p.

4a. Facility Name (If not institution, give street and number)

Manor Care Nursing Home

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

421-03-4412

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 13, 1918

9. Birthplace (State or Foreign Country)

Alabama

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2300 Parallel Lane

10f. Zip Code

20904

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

9th

College (1-4 or 5+)

College

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Conductor

16b. Kind of Business/Industry

Southern Railroad

17. Father's Name (First, Middle, Last)

Robert Hannon

18. Mother's Name (First, Middle, Maiden Surname)

Louise Files

19a. Informant's Name/Relationship (Type, Print)

Carnell Hannon (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9000 Briarcroft Lane, Laurel, MD 20708

20a. Method of Disposition

☐ Burial ☐ Cremation ☒ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Home

Johnson Mem. Funeral

18/14/96

Bessemer, AL

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21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SNOWDEN FUNERAL HOME, P.A.

ROCKVILLE, MD 20850

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

Immediate Cause (Final

disease or condition

resulting in death)

a. End stage Carcinoma Prostate

Due to (or as a consequence of):

b. With Bone metastasis

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,

if any, leading to immediate

cause. Enter Underlying

Cause (Disease or injury

that initiated events

resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy

performed?

☐ Yes ☒ No

24b. Were autopsy findings

available prior to

completion of cause

of death?

☐ Yes ☐ No

25. Was case referred to medical

examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending

Investigation

☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

M

28c. Injury at

Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier

(Check only

one)

29b. Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

MOBARAK KARIM MD

D-18895

August 14, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOBARAK KARIM, 7610 CARROLL AVENUE, TAKOMA PARK, MD 20912

31. Date filed (Month, Day, Year)

AUG 15 1996

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

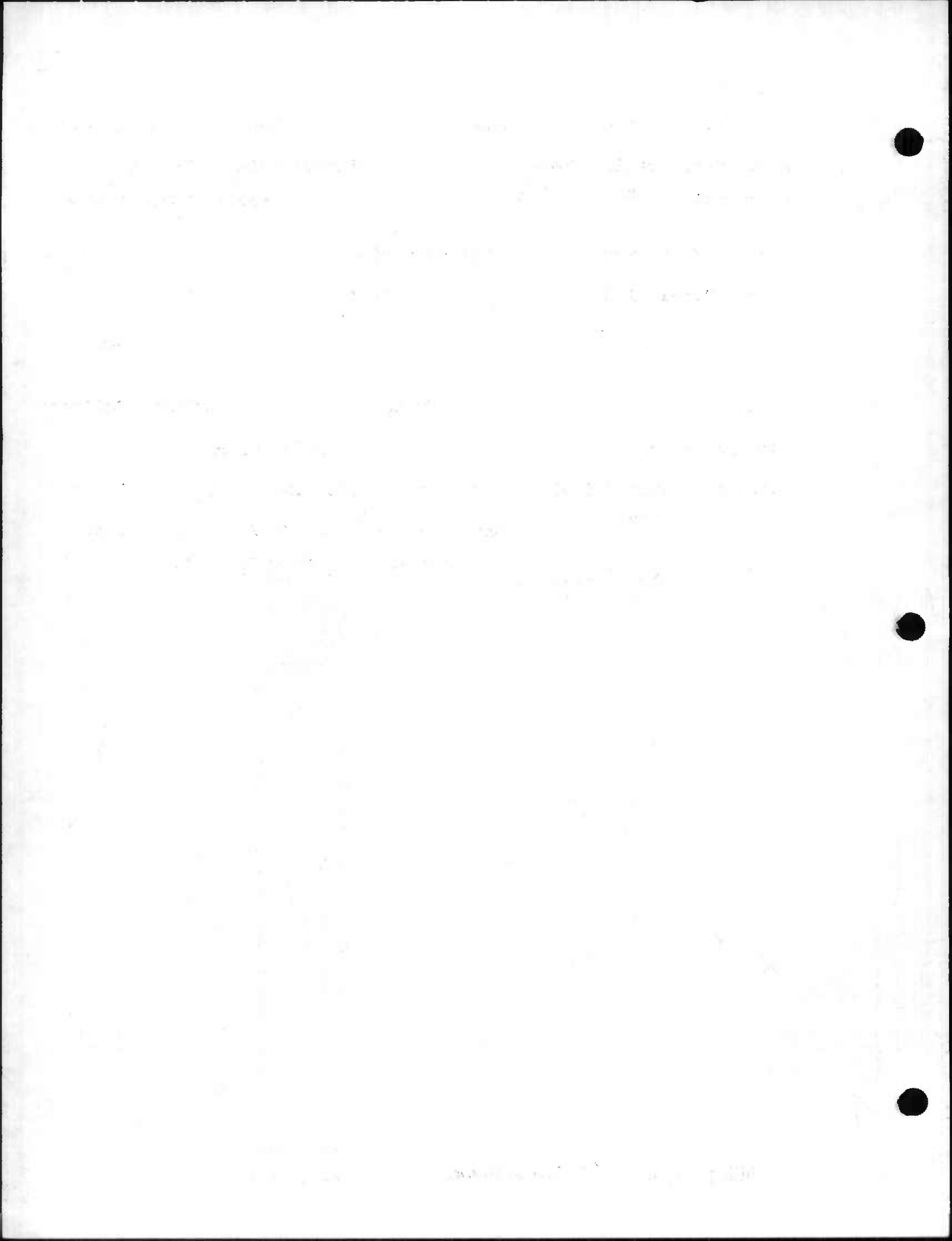
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25563

Amended #17, 8/12/96, JW, MontCty.

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Elizabeth Hussey Johnson

2. Date of Death

Month Day Year  
August 4, 1996

3. Time of Death

1:00 P.M.

4a. Facility Name (If not institution, give street and number)

407 Russell Avenue #406

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

5. Social Security Number

579-32-0084

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 7, 1910

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

407 Russell Avenue Apt. #406

10f. Zip Code

20877

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

~~William~~ John Barton Hussey

18. Mother's Name (First, Middle, Maiden Surname)

Eva Kate Holmes

19a. Informant's Name/Relationship (Type, Print)

William C. Kelly, Jr./Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11718 Yates Ford Road, Fairfax Station, VA. 22039

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Bethany Cemetery

Date

8/9/96

20c. Location - City or Town, State

Aiken, South Carolina

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home

10 East Deer Park Dr., Gaithersburg, MD. 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Ventricular Fibrillation

Due to (or as a consequence of):

minutes

b. Chronic Hypertension

Due to (or as a consequence of):

years

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

Hypothyroidism

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Pending investigation☐ Accident☐ Suicide☐ Homicide☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury et

Work?

☐ Yes ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M.D.

29c. License number

D 19042

29d. Date signed (Month, Day, Year)

August 5, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Byrl D. Johnson, M.D., 911 Russell Avenue, Gaithersburg, Maryland 20879

31. Date filed (Month, Day, Year)

AUG 12 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 25564  
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ruth Gisnet Judis				2. Date of Death Month Day Year August 12, 1996		3. Time of Death 2:42 AM		
	4e. Facility Name (If not institution, give street and number) Allegis Health & Rehabilitation Center-Kensington				4b. City, Town, or Location of Death Kensington		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 325-03-3709		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) July 25, 1915		
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) Illinois		10. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Kensington		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 3000 McComas Avenue		10f. Zip Code 20895		10g. Citizen of What Country? United States					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dress Designer		16b. Kind of Business/Industry Clothing					
17. Father's Name (First, Middle, Last) Barney Gisnet				18. Mother's Name (First, Middle, Maiden Surname) Sophie Robbins					
19a. Informant's Name/Relationship (Type, Print) John B. Judis				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1428 Winding Way Lane, Silver Spring, MD 20902					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		Date 8-12-96		20c. Location - City or Town, State Beltsville, Maryland			
21. Signature of Funeral Service Licensee Ellen H. Rapp		22. Name and Address of Facility Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Multiple Cerebral Infarction Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death years							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Lung Cancer		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Martin C. Shargel						29c. License number D 08944	
29d. Date signed (Month, Day, Year) August 12, 1996		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Martin C. Shargel, M. D., 3720 Farragut Avenue, Kensington, MD 20895							
31. Date filed (Month, Day, Year) AUG 13 1996		32. Registrar's Signature Julia Davidson-Randall							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural," or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



96 25565

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Shelley Marie Johnson</i>				2. DATE OF DEATH MONTH <i>August</i> DAY <i>09</i> YEAR <i>1996</i>		3. TIME OF DEATH <i>0307 A M</i>	
4. SOCIAL SECURITY NUMBER <i>236-82-6582</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>36</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Feb. 15, 1960</i>	
8a. FACILITY NAME (If not institution, give street and number) <i>SHADY GROVE ADVENTIST HOSPITAL</i>				8b. CITY, TOWN OR LOCATION OF DEATH <i>ROCKVILLE</i>		8c. COUNTY OF DEATH <i>MONTGOMERY</i>	
9. RESIDENCE OF DECEDENT				10a. STATE <i>Maryland</i>		10b. COUNTY <i>Montgomery</i>	
10c. CITY, TOWN OR LOCATION <i>Gaithersburg</i>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <i>8209 Gallery Court</i>	
10f. ZIP CODE <i>20879</i>				10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>4</i> College (1-4 or 5+) <i>4</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Dental Hygienist</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Dentistry</i>	
17. FATHER'S NAME (First, Middle, Last) <i>James E. Swann</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Constance L. Petrini</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Robert L. Johnson</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>8209 Gallery Court, Gaithersburg, Maryland 20879</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>August 12, 1996</i> <i>Mt. Calvary Cemetery</i>		20c. LOCATION — City or Town, State <i>Wheeling, West Virginia</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Barbara J. McMullen Lawrence</i> M00831				22. NAME AND ADDRESS OF FACILITY <i>Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>SUPERIOR VENA CAVA SYNDROME</i> DUE TO (OR AS A CONSEQUENCE OF): <i>REFRACTORY NONHODGKINS LYMPHOMA</i> DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>HYPOXEMIC RESPIRATORY FAILURE</i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29. SIGNATURE AND TITLE OF CERTIFIER <i>Carolyn Hendricks MD</i>				29c. LICENSE NUMBER <i>D 37234</i>		29d. DATE SIGNED (Month, Day, Year) <i>AUGUST 09 1996</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>CAROLYN HENDRICKS MD 9707 MEDICAL CENTER DR ROCKVILLE MD 20850</i>				31. DATE FILED (Month, Day, Year) <i>AUG 12 1996</i>			
31. REGISTRAR'S SIGNATURE <i>John Davidson-Hendell</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25566

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>PAUL L. JONES</b>				2. Date of Death Month Day Year <b>AUG. 9, 1996</b>		3. Time of Death <b>6:18 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>MONTGOMERY GENERAL HOSPITAL</b>				4b. City, Town, or Location of Death <b>OLNEY</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>578-05-8920</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>83</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>NOV. 26, 1912</b>		9. Birthplace (State or Foreign Country) <b>WASH. D.C.</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD.</b>	10b. County <b>MONTGOMERY</b>	10c. City, Town or Location <b>WHEATON</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>12914 ESTELLE RD.</b>			10f. Zip Code <b>20906</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>1</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SALESMAN</b>		16b. Kind of Business/Industry <b>CLOTHING</b>		
	17. Father's Name (First, Middle, Last) <b>JOHN FRANCIS JONES</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ANNA LEMAR</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>MARION D. JONES/WIFE</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>SAME AS ITEM #10</b>				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CHAMBERS CREMATORY</b>		Date <b>8/10</b>		20c. Location - City or Town, State <b>RIVERDALE, MD.</b>	
	21. Signature of Funeral Service Licenses <b>W.W. Chambers</b>				22. Name and Address of Facility <b>W. W. CHAMBERS CO. INC., SILVER SPRING, MD. 20910</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. METASTATIC CARCINOMA</b> Due to (or as a consequence of): <b>b. LUNG CARCINOMA</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>NON INSULIN DEPENDENT DIABETES MELLITUS</b> <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b>							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier <b>Cezar A. Lopez M.D.</b>				29c. License number <b>D15405</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 9, 1996</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>CEZAR A. LOPEZ M.D. 18111 PRINCE PHILIP DR. #104, OLNEY, MD. 20832</b>							
31. Date filed (Month, Day, Year) <b>AUG 12 1996</b>		32. Registrar's Signature <b>J. Davidson-Randall</b>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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State of Maryland / Department of Health and Mental Hygiene

96 25567

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>THOMAS KEATON KOGER</b>						2. Date of Death Month Day Year <b>AUG 18 1996</b>		3. Time of Death <b>4:50 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>NATIONAL NAVAL MEDICAL CENTER</b>						4b. City, Town, or Location of Death <b>BETHESDA</b>		4c. County of Death <b>MONTGOMERY</b>		
Funeral Director	5. Social Security Number <b>None</b>		8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. Months Days <b>16</b>		6. Data of Birth (Month, Day, Year) <b>August 2, 1996</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	10a. State <b>VA</b>		10b. County <b>Fairfax</b>		10c. City, Town or Location <b>Springfield</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
10e. Street and Number <b>7126 Constantine Avenue</b>		10f. Zip Code <b>22150</b>		10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4or 5+) <b>N/A</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>N/A</b>		16b. Kind of Business/Industry <b>N/A</b>		17. Father's Name (First, Middle, Last) <b>Thomas Kent Koger</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Lorrie Pearl Thomas</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Thomas Kent Koger (Father)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7126 Constantine Avenue, Springfield, VA 22150</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arlington National Cemetery 8/23/96 Arlington, VA</b>		20c. Location - City or Town, State			
21. Signature of Funeral Service Licensee <i>Evin Thomas Rouse</i>		22. Name and Address of Facility <b>Affordable Funeral Services</b> <b>2726 Hollywood Avenue, Falls Church, VA 22043</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>SEVERE RESPIRATORY DISTRESS SYNDROME</b> Due to (or as a consequence of): b. <b>EXTREME PREMATURITY</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>R. R. Moores</i>		29c. License number <b>D-41551</b>		29d. Date signed (Month, Day, Year) <b>08/20/96</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>R. R. MOORES, LTC, MC, USA</b> <b>NATIONAL NAVAL MEDICAL CENTER</b> <b>BETHESDA MD 20889-5600</b>		31. Data filed (Month, Day, Year) <b>AUG 27 1996</b>	
32. Registrar's Signature <i>John Davidson-Randall</i>											

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

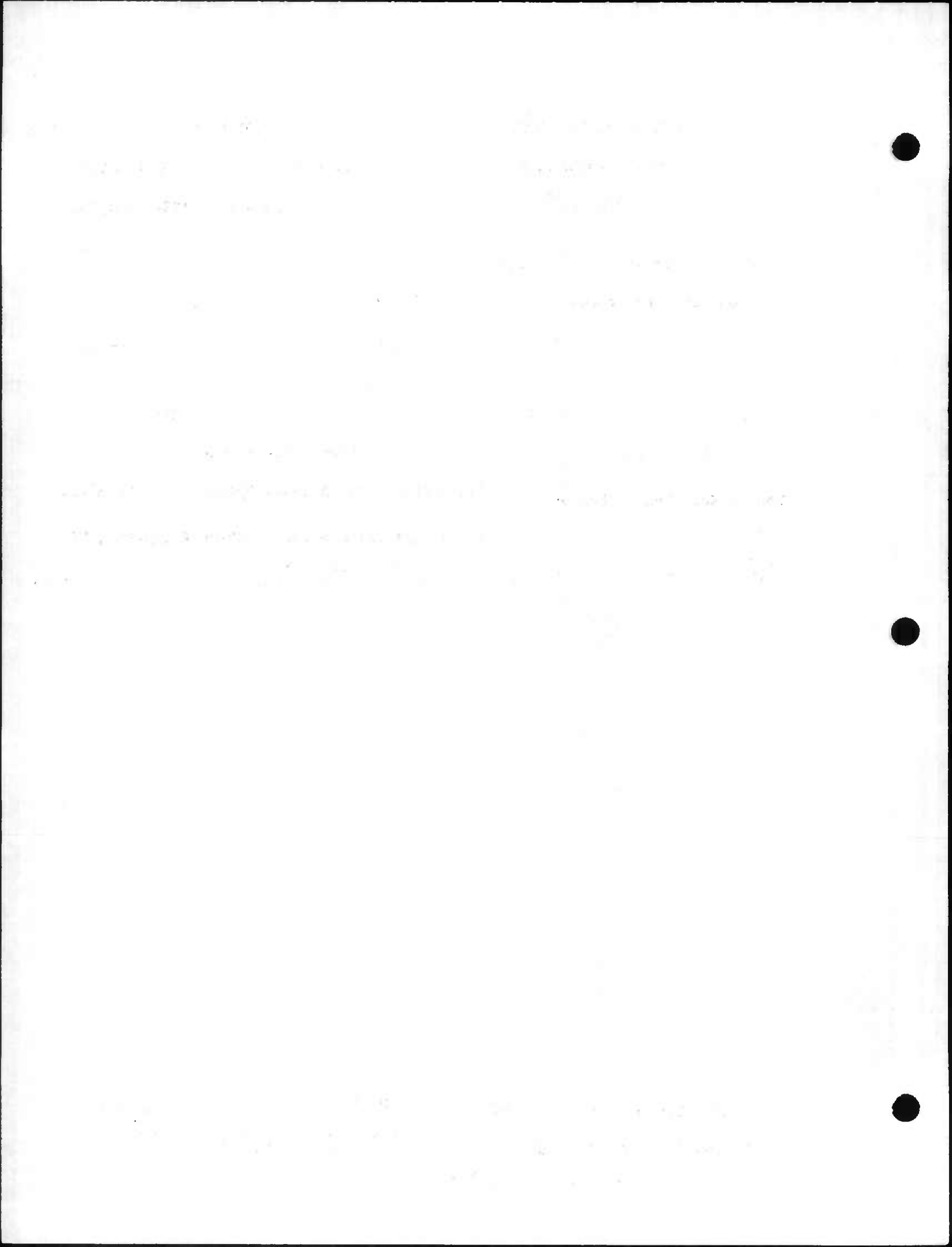
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25568

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Isabell Kilson				2. Date of Death Month Day Year August 8, 1996		3. Time of Death 7:15 P.M.	
	4a. Facility Name (If not institution, give street and number) 222 Clabber Hill Road				4b. City, Town, or Location of Death Centreville		4c. County of Death Queen Annes	
Funeral Director	5. Social Security Number 218-20-5806		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) May 7, 1920	
	9. Birthplace (State or Foreign Country) Maryland		10. Usual Residence of Decedent 10e. State: Maryland 10b. County: Queen Annes 10c. City, Town or Location: Centreville		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number 222 Clabber Hill Road				10f. Zip Code 21617		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 6th College (1-4 or 5+):				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cook		16b. Kind of Business/Industry Domestic	
	17. Father's Name (First, Middle, Last) William Kilson				18. Mother's Name (First, Middle, Maiden Surname) Blanche Cheers			
	19a. Informant's Name/Relationship (Type, Print) Lisa R. Handy				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1714 Batts Neck Road, Stevensville, Md. 21666			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Salem U.M. Church Cem.		20c. Date 8/17/96		20d. Location - City or Town, State Brown's Corner Centreville, Md.	
	21. Signature of Funeral Service Licensee				22. Name and Address of Facility Bennie Smith Funeral Home P.O. Box 1687 Easton, Md. 21601			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Cerebrovascular accident Due to (or as a consequence of): b. Hypertension Due to (or as a consequence of): c. Dysphagia Due to (or as a consequence of): d. Substernal goiter							
	Approximate Interval Between Onset and Death x 5 months years 5 months year							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier Kathleen Hoy				29c. License number D47627		29d. Date signed (Month, Day, Year) 8-12-96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kathleen Hoy 207 N. Liberty St B Centreville Md 21617								
31. Date filed (Month, Day, Year) AUG 13 1996				32. Registrar's Signature Julia Davidson-Randall				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25569

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARY ANNA KEMPER</b>				2. Date of Death Month Day Year <b>AUGUST 8, 1996</b>		3. Time of Death <b>11:20 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Allegis Nursing Home</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>		
Funeral Director	5. Social Security Number <b>214-74-1409</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>90</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct. 18, 1905</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Rockville</b>		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>12214 Hunters Court</b>		10f. Zip Code <b>20852</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>					
17. Father's Name (First, Middle, Last) <b>Joseph Remeikis</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Mautausavich</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Joyce M. Grossman</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12214 Hunters Court Rockville, Maryland 20852</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Glenhaven Memorial Park</b>		20c. Date <b>8/10/96</b>		20d. Location - City or Town, State <b>Glen Burnie, Maryland</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., Maryland 20901</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>e. Cerebral Vascular Accident</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>1 Hour</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b>									
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier 				29c. License number <b>D 25947</b>		29d. Date signed (Month, Day, Year) <b>August 9, 1996</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Evelyn D. Jackson, M.D. 3416 Olandwood Court #200 Olney, Maryland 20832</b>									
31. Date filed (Month, Day, Year) <b>AUG 12 1996</b>				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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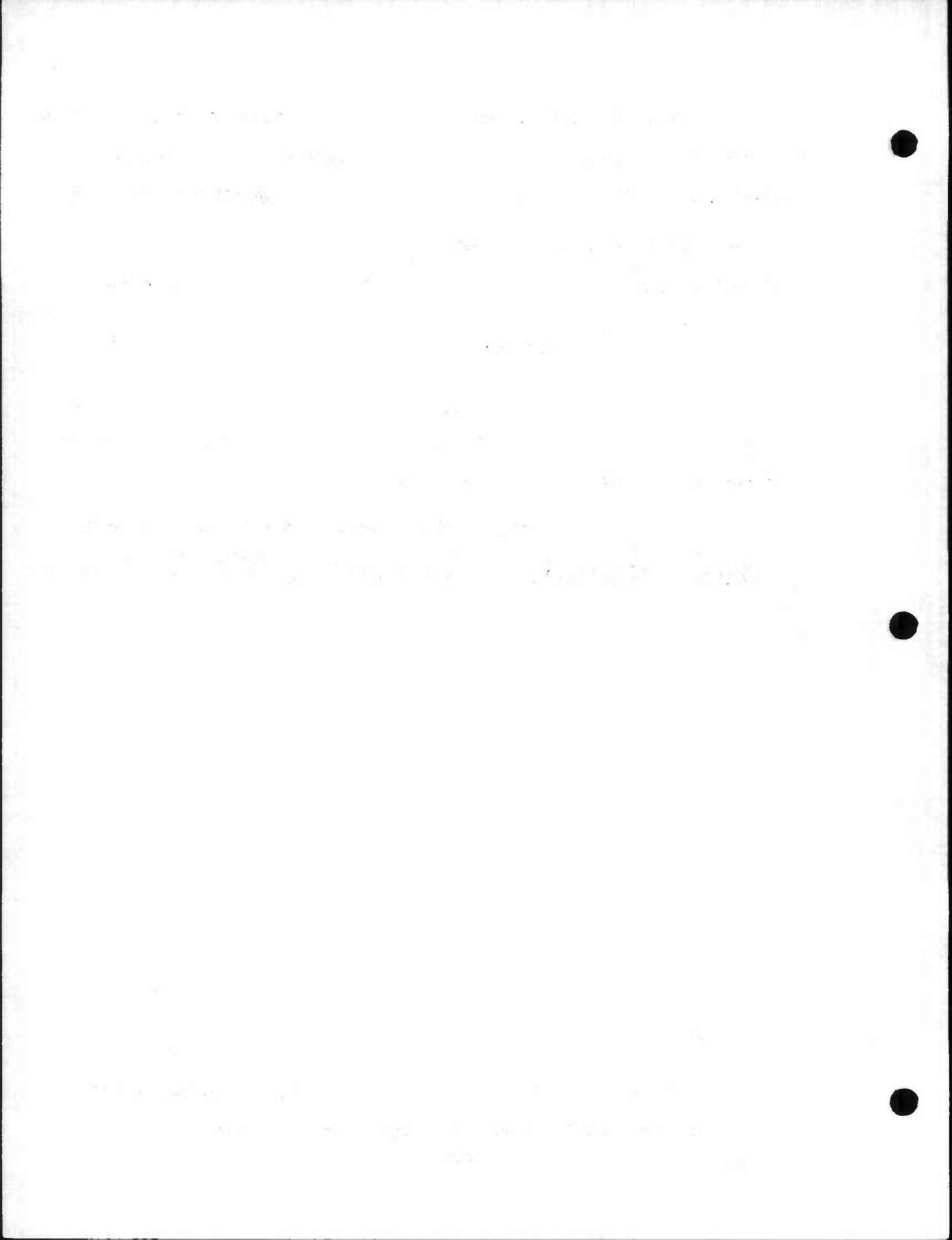
State of Maryland / Department of Health and Mental Hygiene

96 25570

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Eugene Richard Kellaheer</b>				2. Date of Death Month <b>August</b> Day <b>6</b> , Year <b>1996</b>				3. Time of Death <b>4:45 P.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Prince George's Hospital Center</b>				4b. City, Town, or Location of Death <b>Cheverly</b>				4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>216-30-4124</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>63</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 11, 1933</b>		9. Birthplace (State or Foreign Country) <b>New York</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Greenbelt</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>13 Empire Place</b>				10f. Zip Code <b>20770</b>				10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1953-1955</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Program Analyst</b>				16b. Kind of Business/Industry <b>U.S. Government</b>	
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>William Joseph Kellaheer</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Alice Agnes Devaney</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Joanne Kellaheer (wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>same as #10</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Maryland Veterans Cemetery</b>				20c. Location - City or Town, State <b>Cheltenham, Maryland</b>	
	21. Signature of Funeral Service Licensee <i>Donald V. Borgwardt</i>				22. Name and Address of Facility <b>Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. <i>Serious</i></b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. <i>Severe</i></b> Due to (or as a consequence of): <b>c. <i>Severe</i></b> Due to (or as a consequence of): <b>d. <i>Severe</i></b>								Approximate Interval Between Onset and Death <b>4 weeks</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Renal failure, adult respiratory distress syndrome, water ionostic cardiovascular disease</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier <i>David S. Granite, MD</i>				29c. License number <b>D17572</b>				29d. Date signed (Month, Day, Year) <b>August 7, 1996</b>	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David S. Granite, M.D. 115 Center Way Greenbelt, Maryland 20770</b>									
	31. Date filed (Month, Day, Year) <b>AUG 12 1996</b>				32. Registrar's Signature <i>John Davidson-Randall</i>					





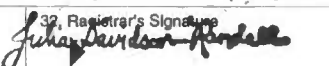
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State of Maryland / Department of Health and Mental Hygiene

96 25571

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Charlotte Kubota</b>				2. Date of Death Month <b>August</b> Day <b>08</b> Year <b>1996</b>		3. Time of Death <b>3:32 p.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Laurel Regional Hospital</b>				4b. City, Town, or Location of Death <b>Laurel</b>		4c. County of Death <b>Prince Georges</b>	
Funeral Director	5. Social Security Number <b>214-28-7646</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>66</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>December 21, 1927</b>	9. Birthplace (State or Foreign Country) <b>Illinois</b>
	Usual Residence of Decedent				10a. State <b>Maryland</b>		10b. County <b>Prince Georges</b>	
To Be Completed by Funeral Director	10c. City, Town or Location <b>Laurel</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>1103 11th St</b>	
	10f. Zip Code <b>20707</b>				10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Supervisor</b>		16b. Kind of Business/Industry <b>Defense Mapping Agency</b>	
	17. Father's Name (First, Middle, Last) <b>Morikeyo Kubota</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Nobu Hori</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Suzanne Kubota (Niece)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10893 Martingale Ct, Frederick, MD 21701</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Fort Lincoln Crematory</b>		20c. Location - City or Town, State <b>Aug 13 Brentwood, MD</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Hines-Rinaldi Funeral Home</b> <b>11800 New Hampshire Ave, Silver Spring, MD 20904</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ALVEOLAR CELL CARCINOMA LUNG</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHRONIC RENAL FAILURE</b> <b>DIABETES MELLITUS</b> <b>HYPERTENSION</b>								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined								
28a. Date of Injury (Month, Day Year)								
28b. Time of Injury <b>M</b>								
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
28d. Describe how Injury occurred								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 								
29c. License number <b>D24997</b>								
29d. Date signed (Month, Day, Year) <b>8/12/96</b>								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>LUIS A. CASAS MD 8317 CHERRY LANE LAUREL MD 20707</b>								
31. Date filed (Month, Day, Year) <b>AUG 14 1996</b>								
32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

96 25572

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Nelson H. Kobren				2. Date of Death Month August Day 9 Year 1996		3. Time of Death 0916 AM			
	4a. Facility Name (If not institution, give street and number) 411 Apple Grove Road				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery			
Funeral Director	5. Social Security Number 578-40-5754		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 65 Yrs.		8. Date of Birth (Month, Day, Year) July 25, 1931		9. Birthplace (State or Foreign Country) Washington, DC	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 411 Apple Grove Road				10f. Zip Code 20904		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1954-1991		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher			16b. Kind of Business/Industry Education		
	17. Father's Name (First, Middle, Last) Samuel Byron Kobren				18. Mother's Name (First, Middle, Maiden Surname) Pauline Mavisky					
	19a. Informant's Name/Relationship (Type, Print) William Alan Kobren / Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PSC 9 Box 502 A.P.O. AE 09123					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cem.		20c. Location - City or Town, State 8/16/96 Arlington, Virginia					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MYOCARDIAL INFARCTION Due to (or as a consequence of): b. CARDIOMYOPATHY Due to (or as a consequence of): c. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ACUTE INDEF INDEF									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
23c. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										
23d. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS										
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 				29c. License number D07099		29d. Date signed (Month, Day, Year) AUG 13 96				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANCIS C MAYLE 10215 FERNWOOD RD BETHESDA MD 20814										
31. Date filed (Month, Day, Year) AUG 14 1996										
32. Registrar's Signature 										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar



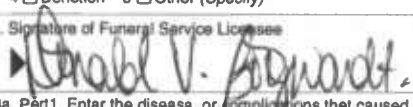

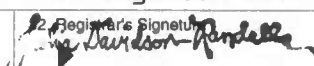
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State of Maryland / Department of Health and Mental Hygiene

96 25573

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Helen C. Krug</b>				2. Date of Death Month <b>August</b> Day <b>7</b> , Year <b>1996</b>		3. Time of Death <b>12:48P.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Doctor's Community Hospital</b>				4b. City, Town, or Location of Death <b>Lanham</b>		4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>216-22-3060</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>71</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day, Year) <b>June 8, 1925</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>College Park</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>5126 Mangum Road</b>				10f. Zip Code <b>20740</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>			18b. Kind of Business/Industry <b>Own Home</b>	
17. Father's Name (First, Middle, Last) <b>Philip P. Clarke</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Helen Norris</b>				
19a. Informant's Name/Relationship (Type, Print) <b>George A. Krug (husband)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>same as #10</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Fort Lincoln Cemetery</b>		Data <b>8/9/1996</b>		20c. Location - City or Town, State <b>Brentwood, Maryland</b>
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>CARDIAC FAILURE</b> Due to (or as a consequence of): b. <b>ACUTE MYOCARDIAL INFARCTION</b> Due to (or as a consequence of): c. <b>DIABETES MELLITUS</b> Due to (or as a consequence of): d. <b>ESSENTIAL HYPERTENSION</b>								Approximate Interval Between Onset and Death  <b>1 day</b>  <b>1 day</b>  <b>1975</b>  <b>1964</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number <b>D13668</b>		29d. Date signed (Month, Day, Year) <b>August 8, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Azher Hussain, M.D. 4917 Edgewood Road College Park, Maryland 20740</b>								
31. Date filed (Month, Day, Year) <b>AUG 12 1996</b>				Registrar's Signature 				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that proper record-keeping is essential for the integrity of the financial system and for the ability to detect and prevent fraud.

2. The second part of the document outlines the specific procedures for recording transactions. It details the steps involved in the accounting process, from the initial entry of data into the system to the final review and approval of the records.

3. The third part of the document addresses the issue of data security. It discusses the various risks associated with the loss or theft of financial data and provides recommendations for implementing effective security measures to protect the information.

4. The fourth part of the document discusses the importance of regular audits. It explains how audits can help to identify errors and discrepancies in the records and ensure that the system is operating in accordance with established standards and regulations.

5. The fifth part of the document discusses the importance of training and education for staff involved in the financial system. It emphasizes that ongoing training is necessary to ensure that staff are up-to-date on the latest procedures and technologies and are able to perform their duties effectively and efficiently.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25574

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>VIVIAN C. KIMUTAI</b>				2. Date of Death Month Day Year <b>AUGUST 10, 1996</b>		3. Time of Death <b>7:56 P.M.</b>	
	4a. Facility Name (If not Institution, give street and number) <b>SHADY GROVE ADVENTIST HOSPITAL</b>				4b. City, Town, or Location of Death <b>ROCKVILLE</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>None</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. <b>8</b>		8. Date of Birth (Month, Day, Year) <b>Sept 23, 1987</b>	
	9. Birthplace (State or Foreign Country) <b>Kenya</b>		10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Potomac</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <b>10201 Sorrel Avenue</b>		10f. Zip Code <b>20854</b>		10g. Citizen of What Country? <b>Kenya</b>	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2nd</b> College (1-4 or 5+) <b>Student</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Student</b>		16b. Kind of Business/Industry <b>None</b>		17. Father's Name (First, Middle, Last) <b>Kenneth Kimutai</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>Caroline J. Chepkwony</b>		19a. Informant's Name/Relationship (Type, Print) <b>Matthew K. Mithiri (Embassy Staff)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2249 R St., NW, Washington, DC 20008</b>		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Family Cemetery</b>		20c. Location - City or Town, State <b>Kenya</b>		20d. Date <b>8/13/96</b>		20e. Location - City or Town, State <b>Kapsawar, Marakwet</b>	
	21. Signature of Funeral Service Licensee <i>George R. Snowden</i>		22. Name and Address of Facility <b>SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. ASPHYXIA, SECONDARY TO DROWNING</b>		Approximate Interval Between Onset and Death <b>20 MIN.</b>	
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 8 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>AUGUST 10, 1996</b>	
	28b. Time of Injury <b>6:50 P.M.</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>DROWNED IN POOL</b>		28e. Location (Street and Number or Rural Route Number, City or Town, State) <b>AT HOME 10201-SORREL AVE POTOMAC, MD</b>	
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Victor H. Esch, M.D.</b>		29c. License number <b>DO 1968</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 10, 1996</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>VICTOR H. ESCH, M.D. 10717-STANMORE DRIVE POTOMAC, MD 20854</b>		31. Date filed (Month, Day, Year) <b>AUG 13 1996</b>		32. Registrar's Signature <i>John Davidson-Rodriguez</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

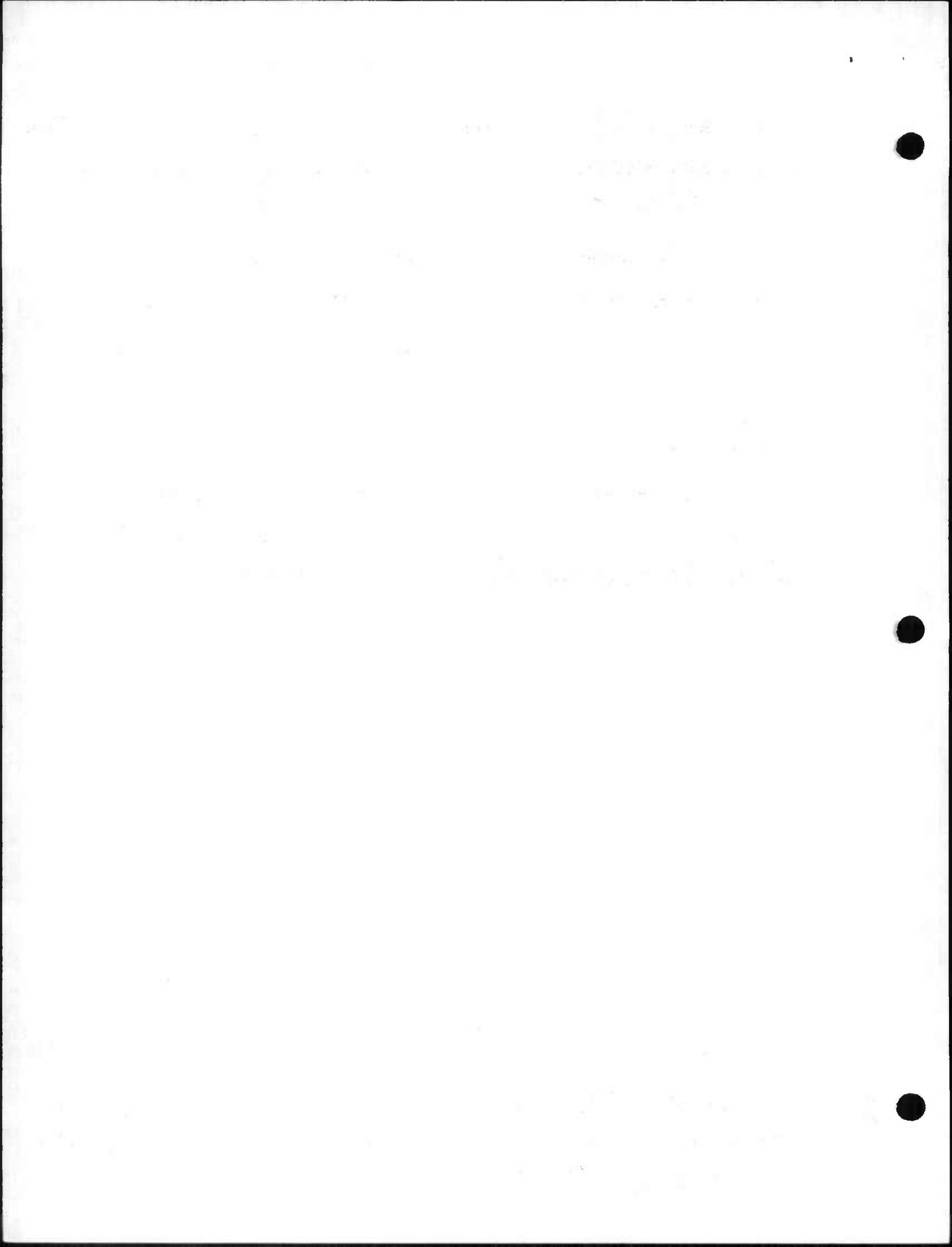
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 25575

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Emily Lednum

2. Date of Death

Month  
08Day  
09Year  
1996

3. Time of Death

1:00 p.m.

4a. Facility Name (If not institution, give street and number)

Caroline Nursing Home, Inc.

4b. City, Town, or Location of Death

Denton

4c. County of Death

Caroline

Funeral  
Director

5. Social Security Number

220-01-5962A

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 19, 1919

9. Birthplace (State or Foreign Country)

Neavitt, MD

Usual Residence of Decedent

10e. State

MD

10b. County

Talbot

10c. City, Town or Location

Tilghman

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

21528 East Mission Rd.

10f. Zip Code

21671

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Charles D. Cooper

18. Mother's Name (First, Middle, Maiden Surname)

Florence Haddaway

19a. Informant's Name/Relationship (Type, Print)

Richard W. Lednum, Sr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 153 East Mission Rd., Tilghman, MD 21671

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Wesleyan Church Cem.

Date

8/13

20c. Location - City or Town, State

Tilghman, MD 21671

21. Signature of Funeral Service Licensee

JOHN R. MERCER, CFS

22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME  
200 S. HARRISON ST., EASTON, MD 2160123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

24 hours

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. COPD

Due to (or as a consequence of):

10+ years

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's Dementia, DJD

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Rb Lappin MD

29c. License number

D33294

29d. Date signed (Month, Day, Year)

8/9/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rb Lappin MD 920 market St. Denton, MD 21629

31. Date filed (Month, Day, Year)

AUG 12 1996

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

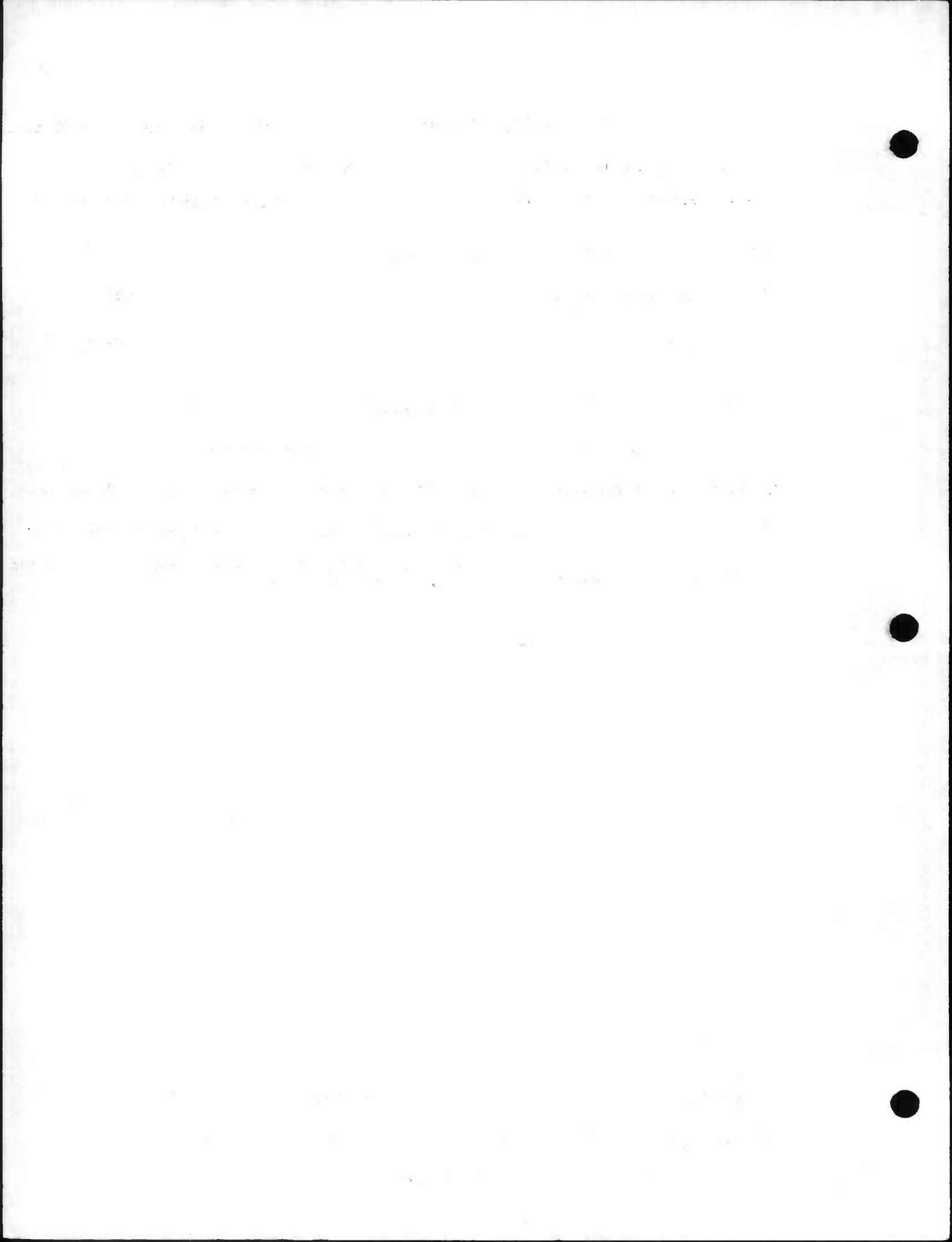
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25576

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John William Lambert, Sr.

2. Date of Death  
Month Day Year

August 12, 1996

3. Time of Death

12:20 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

5. Social Security Number

229-07-1305

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov 12, 1920

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Damascus

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

26700 Howard Chapel Drive

10f. Zip Code

20872

10g. Citizen of What Country?

American

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Owner-Manager

16b. Kind of Business/Industry

Auto Supply Store

17. Father's Name (First, Middle, Last)

Milton Lambert

18. Mother's Name (First, Middle, Maiden Surname)

Grace Irwin

19a. Informant's Name/Relationship (Type, Print)

John W. Lambert, Jr. Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

26217 Johnson Drive, Damascus, Maryland 20872

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☒ Other (Specify) Entombment

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Boyer Memorial Chapel

Date

8/15/96

20c. Location - City or Town, State

Damascus, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Olin L. Molesworth, P.A., Funeral Home

26401 Ridge Road, Damascus, Maryland

20872

23a. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PULMONARY EMBOLISM

Due to (or as a consequence of):

ACUTE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. FRACTURED HIP

Due to (or as a consequence of):

4 DAYS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☒ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

Aug. 8, 1996

28b. Time of Injury

A. M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Bedroom - at home.

28d. Describe how injury occurred

Fell getting out of bed.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

26700 Howard Chapel Drive

Damascus, Maryland

20872

29a. Certifier  
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29b. Signature and title of certifier

29c. License number

D07099

29d. Date signed (Month, Day, Year)

August 12, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Francis C. Mayle, M.D. 10215 Fernwood Road, Bethesda, Maryland 20817

31. Date filed (Month, Day, Year)

AUG 14 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State  
Registrar



ML

ITEMS: 23 PART I, 27, 28a-f, PER State of Maryland / Department of Health and Mental Hygiene

96 25577

NEO FILM G-738 8/30/96 t.t

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>PAUL JOSEPH MOORE, SR.</b>				2. Date of Death Month Day Year <b>JULY 10 1996</b>		3. Time of Death <b>4:40 PM</b>			
	4a. Facility Name (If not institution, give street and number) <b>UNION HOSPITAL</b>				4b. City, Town, or Location of Death <b>ELKTON</b>		4c. County of Death <b>CECIL</b>			
Funeral Director	5. Social Security Number <b>198-52-0051</b>	6. Sex <b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>36</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>NOV 5, 1959</b>		9. Birthplace (State or Foreign Country) <b>PA</b>		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>		10b. County <b>CECIL</b>		10c. City, Town or Location <b>CHESAPEAKE CITY</b>		10d. Inside City Limits <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>			
	10e. Street and Number <b>1425 Augustine Herman Highway</b>				10f. Zip Code <b>21919</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</b>		14. Race - American Indian, Black, White, etc. <b>Specify: WHITE</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MECHANIC</b>		16b. Kind of Business/Industry <b>AUTO</b>					
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>HARRY LEE MOORE SR.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>GLADYS JOHNSON</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>HARRY LEE MOORE SR. - FATHER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1425 Augustine Herman Highway Chesapeake City MD 21919</b>					
	20a. Method of Disposition <b>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>RA PERLIS INC.</b>		20c. Location - City or Town, State <b>7/16/96 Westchester PA.</b>		20d. Date <b>7/16/96</b>			
	21. Signature of Funeral Service Licensee <b>Edgar McK...</b>				22. Name and Address of Facility <b>Dee Funeral Home 259 E. MAIN ST. ELKTON MD 21921</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ACUTE ALCOHOL INTOXICATION</b> Due to (or as a consequence of):  <b>b. Due to (or as a consequence of):</b>  <b>c. Due to (or as a consequence of):</b>  <b>d. Due to (or as a consequence of):</b>  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
	23b. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b>									
	24a. Was an autopsy performed? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>				24b. Were autopsy findings available prior to completion of cause of death? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>					
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>		26. Place of Death (Check only one) Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>							
	27. Manner of Death <b>1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b> <b>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined</b>		28a. Date of Injury (Month, Day, Year) <b>7/10/96</b>		28b. Time of Injury <b>UNKNOWN M</b>		28c. Injury at Work? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>		28d. Describe how injury occurred <b>EXCESSIVE ALCOHOL CONSUMPTION</b>	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>RESIDENCE</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>1425 AUGUSTINE HERMAN HIGHWAY, CHESAPEAKE CITY, MARYLAND</b>					
	29e. Certifier (Check only one) <b>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>									
State Registrar	29b. Signature and title of certifier <b>David R Fowler</b>				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>JULY 11, 1996</b>			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>									
State Registrar	31. Date filed (Month, Day, Year) <b>AUG 27 1996</b>				32. Registrar's Signature <b>Jodi Davidson-Randall</b>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25578

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ANN Murfitt</b>				2. Date of Death Month <b>August</b> Day <b>15</b> Year <b>1996</b>		3. Time of Death <b>3:05am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Memorial Hospital at Easton</b>				4b. City, Town, or Location of Death <b>Easton</b>		4c. County of Death <b>Talbot</b>	
Funeral Director	5. Social Security Number <b>108-26-8673</b>		6. Sex <b>1</b> <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>62</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>APR. 27, 1934</b>	
	9. Birthplace (State or Foreign Country) <b>OHIO</b>		10a. State <b>MD</b>		10b. County <b>TALBOT</b>		10c. City, Town or Location <b>TILGHMAN</b>	
Usual Residence of Decedent								
10d. Inside City Limits <b>1</b> <input checked="" type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No								
10e. Street and Number <b>5760 HARRISON LANE</b>								
10f. Zip Code <b>21671</b>								
10g. Citizen of What Country? <b>USA</b>								
11. Marital Status <b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input checked="" type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced								
12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:								
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No Specify:								
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>								
15. Decedent's Education (Specify only highest grade completed) <b>12</b> Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)								
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>ACCOUNTS REC. CLERK</b>								
16b. Kind of Business/Industry <b>MANUFACTURING</b>								
17. Father's Name (First, Middle, Last) <b>JOSEPH FRIEDMAN</b>								
18. Mother's Name (First, Middle, Maiden Surname) <b>HELEN INMAN</b>								
19a. Informant's Name/Relationship (Type, Print) <b>JOHN J. MURFITT</b>								
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. BOX 54, TILGHMAN, MD 21671</b>								
20a. Method of Disposition <b>1</b> <input type="checkbox"/> Burial <b>2</b> <input checked="" type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)								
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CHESAPEAKE CREMATION CENTER, I.L.C.</b>								
20c. Location - City or Town, State <b>8-16 CHESTER, MD</b>								
21. Signature of Funeral Service Licensee <b>M. E. Newnam III</b> <b>CFSP</b>								
22. Name and Address of Facility <b>FELLOWS, HELFENBEIN &amp; NEWNAM FUNERAL HOME</b> <b>200 S. HARRISON ST., EASTON, MD 21601</b>								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Septic</b> Due to (or as a consequence of): <b>Acute Myelogenous Leukemia</b> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								
Approximate Interval Between Onset and Death <b>2 wks</b> <b>6 mos</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No <b>3</b> <input type="checkbox"/> Probably <b>4</b> <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No								
25. Was case referred to medical examiner? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <b>1</b> <input checked="" type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA Other: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)								
27. Manner of Death <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide								
28a. Date of Injury (Month, Day, Year)								
28b. Time of Injury <b>M</b>								
28c. Injury at Work? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No								
28d. Describe how injury occurred								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <b>2</b> <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <b>Stephen P. Carney</b>								
29c. License number <b>201225</b>								
29d. Date signed (Month, Day, Year) <b>8-11-96</b>								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>STEPHEN P. CARNEY, M.D., 509 IDLEWILD AVENUE, EASTON, MD</b>								
31. Date filed (Month, Day, Year) <b>AUG 16 1996</b>								
32. Registrar's Signature <b>Julia Davidson-Randall</b>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended #4

State of Maryland / Department of Health and Mental Hygiene

96 25579

08/14/96, BJV, Talbot Co.

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

FRANCES D. MIDDLETON

2. Date of Death

Month Day Year  
AUG. 12 1996

3. Time of Death

11:04 AM

4a. Facility Name (If not institution, give street and number)

406 BRIDGE ST.

4b. City, Town, or Location of Death

EASTON

4c. County of Death

TALBOT

5. Social Security Number

577-84-5069  
004-16-8652

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

JULY 26, 1903

9. Birthplace (State or Foreign Country)

SOUTH CAROLINA

Usual Residence of Decedent

10a. State

MD

10b. County

TALBOT

10c. City, Town or Location

EASTON

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

406 BRIDGE STREET

10f. Zip Code

21601

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

BENJAMIN GRAMMAN

18. Mother's Name (First, Middle, Maiden Surname)

ADELAIDE DuBOS

19a. Informant's Name/Relationship (Type, Print)

DuBOS ARMBRISTER/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

406 BRIDGE STREET, EASTON, MD 21601

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHESAPEAKE CREMATION CENTER, L.L.C.

Date

8-14

20c. Location - City or Town, State

CHESTER, MD

21. Signature of Funeral Service Licensee

JOHN R. MERCERON CFSF

22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME  
200 S. HARRISON ST., EASTON, MD 21601

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION (IMMEDIATE)

Due to (or as a consequence of):

b. H/O ASCVD (YEARS)

Due to (or as a consequence of):

c. CHRONIC BRONCHITIS AND COPD (YEARS)

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accidental3 ☐ Suicidal4 ☐ Homicidal5 ☐ Pending investigation6 ☐ Could not be determined7 ☐ Could not be determined8 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Kevin J. O'Keefe MD

29c. License number

D35259

29d. Date signed (Month, Day, Year)

8/13/96

30. Name and address of person who completed Cause of death (Item 23a) (Type, Print)

KEVIN J. O'KEEFE, M.D., 606 DUTCHMAN'S LANE, EASTON, MD 21601

31. Date filed (Month, Day, Year)

AUG 14 1996

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the report is devoted to a general survey of the situation in the country.

2. The second part of the report is devoted to a detailed analysis of the economic situation.

3. The third part of the report is devoted to a detailed analysis of the social situation.

4. The fourth part of the report is devoted to a detailed analysis of the political situation.

5. The fifth part of the report is devoted to a detailed analysis of the cultural situation.

6. The sixth part of the report is devoted to a detailed analysis of the environmental situation.

7. The seventh part of the report is devoted to a detailed analysis of the international situation.

8. The eighth part of the report is devoted to a detailed analysis of the future prospects.

9. The ninth part of the report is devoted to a detailed analysis of the conclusions.

10. The tenth part of the report is devoted to a detailed analysis of the recommendations.

11. The eleventh part of the report is devoted to a detailed analysis of the annexes.

12. The twelfth part of the report is devoted to a detailed analysis of the bibliography.

13. The thirteenth part of the report is devoted to a detailed analysis of the index.

14. The fourteenth part of the report is devoted to a detailed analysis of the appendices.

15. The fifteenth part of the report is devoted to a detailed analysis of the conclusions.

16. The sixteenth part of the report is devoted to a detailed analysis of the recommendations.

17. The seventeenth part of the report is devoted to a detailed analysis of the annexes.

18. The eighteenth part of the report is devoted to a detailed analysis of the bibliography.

19. The nineteenth part of the report is devoted to a detailed analysis of the index.

20. The twentieth part of the report is devoted to a detailed analysis of the appendices.

21. The twenty-first part of the report is devoted to a detailed analysis of the conclusions.

22. The twenty-second part of the report is devoted to a detailed analysis of the recommendations.

23. The twenty-third part of the report is devoted to a detailed analysis of the annexes.

24. The twenty-fourth part of the report is devoted to a detailed analysis of the bibliography.

25. The twenty-fifth part of the report is devoted to a detailed analysis of the index.

26. The twenty-sixth part of the report is devoted to a detailed analysis of the appendices.

27. The twenty-seventh part of the report is devoted to a detailed analysis of the conclusions.

28. The twenty-eighth part of the report is devoted to a detailed analysis of the recommendations.

29. The twenty-ninth part of the report is devoted to a detailed analysis of the annexes.

30. The thirtieth part of the report is devoted to a detailed analysis of the bibliography.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25580

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret Virginia Marrone

2. Date of Death  
Month Day Year

August 13, 1996

3. Time of Death

10:40 p.m.

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

212-72-6380

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

Jan. 17, 1908

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

608 Fairview Avenue

10f. Zip Code

21701

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John M. Miller

18. Mother's Name (First, Middle, Maiden Surname)

Mary Lanora Frye

19a. Informant's Name/Relationship (Type, Print)

Dr. Richard M. Marrone, D.D.S.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

608 Fairview Ave., Frederick, Md. 21701

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Olivet Cemetery

Date

Aug. 16, 1996

20c. Location - City or Town, State

Frederick, Md. 21701

21. Signature of Funeral Service Licensee

*Richard C. Marrone*

M00021

22. Name and Address of Facility

Keeney and Basford Funeral Home

106 East Church St., Frederick, Md. 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. *Congestive Heart Failure*

Due to (or as a consequence of):

b. *Anti Myocardial Infarction*

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

~18 min

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Francis E. Becker MD*

29c. License number

D38496 MD

29d. Date signed (Month, Day, Year)

8/14/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Francis E. Becker MD 300 W 9th St, Frederick MD 21701

31. Date filed (Month, Day, Year)

AUG 16 1996

32. Registrar's Signature

*John Davidson-Robert*State  
Registrar

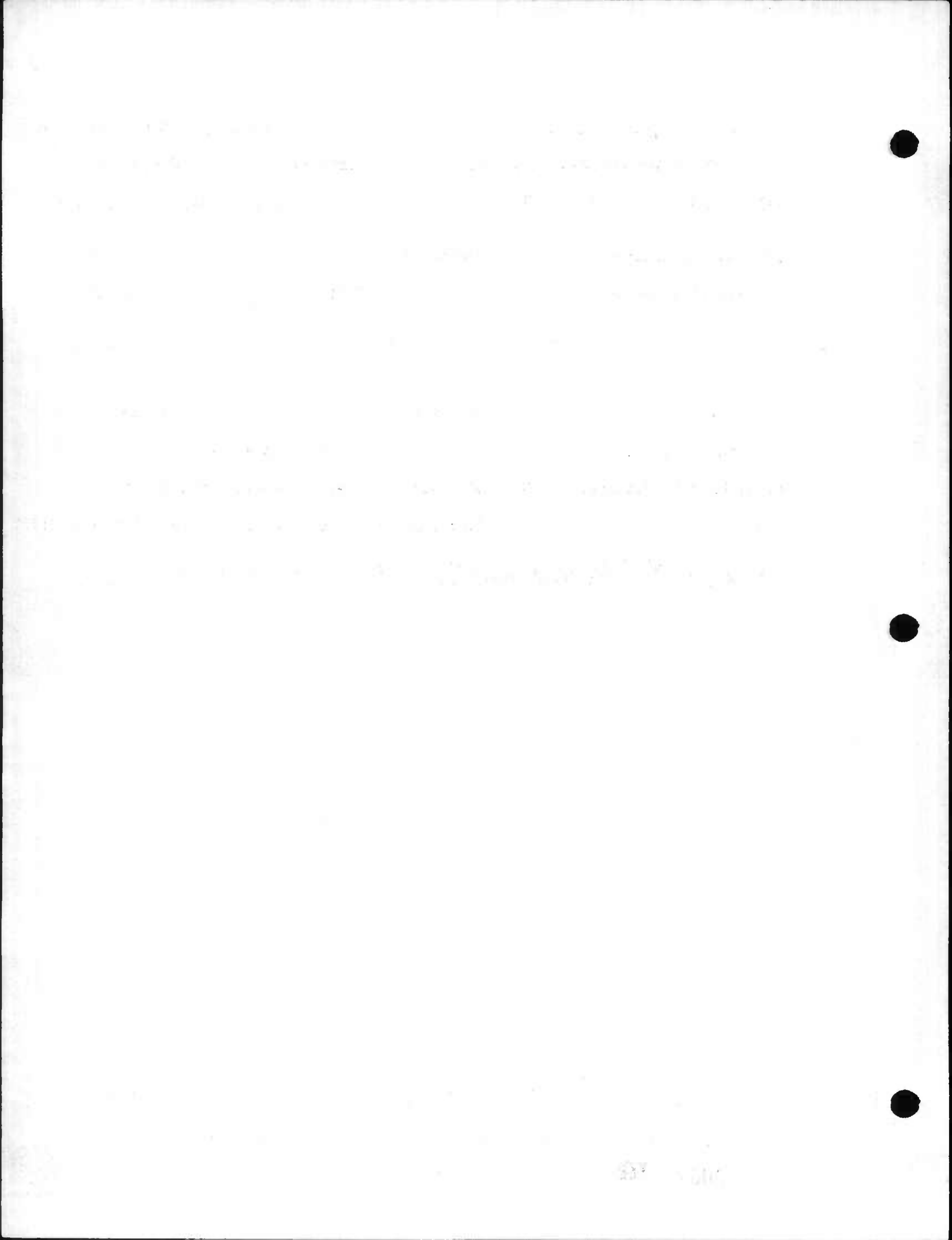
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25581

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LOUISE McMAHAN</b>		2. Date of Death Month <b>July</b> Day <b>18</b> Year <b>1996</b>		3. Time of Death <b>10:40am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Homewood Retirement Center</b>		4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>	
Funeral Director	5. Social Security Number <b>219-36-4167</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>88</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Apr 30, 1908</b>
	9. Birthplace (State or Foreign Country) <b>Maryland</b>					
To Be Completed by Funeral Director	Usual Residence of Decedent					
	10a. State <b>Maryland</b>	10b. County <b>Frederick</b>	10c. City, Town or Location <b>Frederick</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>31 West Patrick Street</b>		10f. Zip Code <b>21701</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>5+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>School Teacher</b>		16b. Kind of Business/Industry <b>Public Education</b>	
	17. Father's Name (First, Middle, Last) <b>Michael Irving</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Nora E. KELLEY</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Mercantile Trust</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>30 North Market Street, Frederick, Maryland 21701</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 1 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Olivet Cemetery Jul 20, 1996</b>		20c. Location - City or Town, State <b>Frederick, Maryland</b>	
	21. Signature of Funeral Service Licensee <i>Kathleen Roberson</i> MO0706		22. Name and Address of Facility <b>Keeney &amp; Basford P.A. Funeral Home 106 East Church Street, Frederick, MD 21701</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						
To Be Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)		a. <b>Congestive Heart Failure</b> Due to (or as a consequence of):		Approximate Interval Between Onset and Death <b>10 years</b>	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):			
			c. Due to (or as a consequence of):			
			d. Due to (or as a consequence of):			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Stroke</b>					
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
	24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier <i>Ali J. Afrookteh</i>		29c. License number <b>D35183</b>		29d. Date signed (Month, Day, Year) <b>July 18, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Ali J. Afrookteh, M.D., 300 West Ninth Street, Frederick, Maryland 21701</b>						
State Registrar	31. Date filed (Month, Day, Year) <b>JUL 24 1996</b>		32. Registrar's Signature <i>Davidson-Randall</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





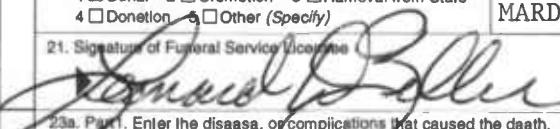
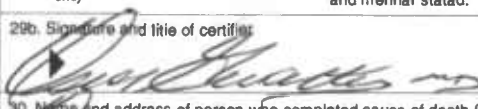
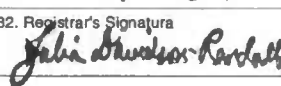
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25582

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GRACE MCKEE</b>		2. Date of Death Month <b>AUGUST</b> Day <b>15</b> Year <b>1996</b>		3. Time of Death <b>1530</b>
	4a. Facility Name (If not Institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>		4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>
Funeral Director	5. Social Security Number <b>229-26-8020</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>108</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year)		9. Birthplace (State or Foreign Country) <b>IRELAND</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State <b>MARYLAND</b>		10b. County <b>WICOMICO</b>
	10c. City, Town or Location <b>MARDELA SPRINGS</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>10840 SHARPTOWN ROAD</b>		10f. Zip Code <b>21837</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5</b> College (1-4 or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SECRETARY</b>		16b. Kind of Business/Industry <b>INSURANCE</b>		
	17. Father's Name (First, Middle, Last) <b>JOHN BENNETT MCKEE</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>MARY BELL</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>LESTER HUSS</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10840 SHARPTOWN ROAD, MARDELA SPRINGS, MD 21837</b>		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MARDELA MEMORIAL CEMETERY</b>		20c. Location - City or Town, State <b>8/18 MARDELA SPRINGS, MD</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>ZELLER FUNERAL HOME, P. O. BOX 207, 106 MAIN STREET, EAST NEW MARKET, MD 21631</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Atherosclerotic Vascular Disease</b> Due to (or as a consequence of): <b>b.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <b>8/15/96</b>		28b. Time of Injury <b>M</b>	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number <b>D47619</b>		29d. Date signed (Month, Day, Year) <b>8/15/96</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JOSE GUALTEROS MD 262 Tilghman Rd Salisbury MD 21804</b>					
State Registrar	31. Date filed (Month, Day, Year) <b>AUG 19 1996</b>		32. Registrar's Signature 		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25583

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Norman Richardson McGaha

2. Date of Death

Month Day Year  
August 7, 1996

3. Time of Death

6:15am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

332 East Diamond Avenue #9

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

5. Social Security Number

214-14-2960

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 24, 1917

9. Birthplace (State or Foreign Country)

Potomac, MD

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

332 East Diamond Avenue #9

10f. Zip Code

20877

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Deputy Sheriff

16b. Kind of Business/Industry

Montgomery Cty., MD

17. Father's Name (First, Middle, Last)

Willie Smith McGaha

18. Mother's Name (First, Middle, Maiden Sumama)

Annie Elizabeth Ray

19a. Informant's Name/Relationship (Type, Print)

Joyce A. Terry (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2140 Mentone Blvd. #79, Mentone, CA 92359

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

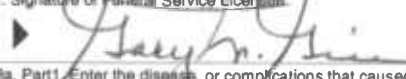
Arlington National Cem.

Date

8/13/96 Arlington, Virginia

20c. Location - City or Town, State

21. Signature of Funeral Service Licentiate



22. Name and Address of Facility

DeVol Funeral Home

10 East Deer Park Dr., Gaithersburg, MD 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PULMONARY FIBROSIS

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D26540

29d. Date signed (Month, Day, Year)

Aug. 9 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carl I. Schoenberger 16220 Frederick Rd. Gaithersburg

31. Date filed (Month, Day, Year)

AUG 12 1996

32. Registrar's Signature



State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

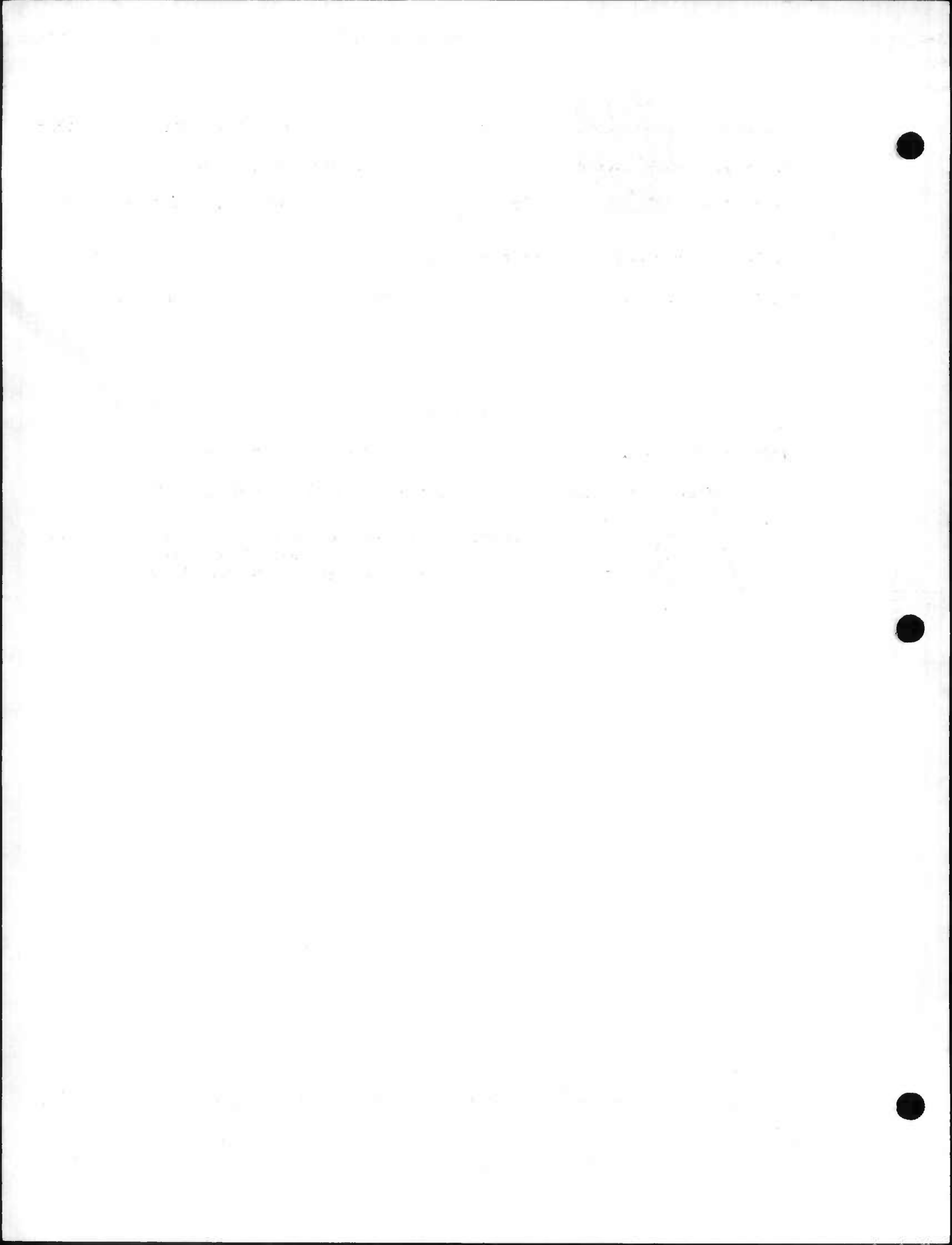
Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.




Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25584

Amended #10f, 19b, 8/16/96 JW Mont, Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Roy Hollis Markham</b>		2. Date of Death Month <b>August</b> Day <b>12</b> Year <b>1996</b>		3. Time of Death <b>11:40 pm</b>
	4a. Facility Name (If not Institution, give street and number) <b>3964 Bel Pre Road #5</b>		4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>
Funeral Director	5. Social Security Number <b>423-46-8862</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>58</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Feb. 18, 1938</b>		9. Birthplace (State or Foreign Country) <b>Alabama</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <b>Maryland</b>	10b. County <b>Montgomery</b>	10c. City, Town or Location <b>Silver Spring</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>3964 Bel Pre Road, #5</b>		10f. Zip Code <b>20902 20906</b>		10g. Citizen of What Country? <b>United States</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1956-1977</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Police Officer</b>		16b. Kind of Business/Industry <b>US Government</b>		
	17. Father's Name (First, Middle, Last) <b>Rudolphus Lamont Markham</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Lona Mae Perry</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Laurel F. Markham/Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3964 Bel Pre Road, #5, Silver Spring, MD 20902</b>		
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>Entombment</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hillcrest Memorial Gardens Mausoleum</b>		20c. Location - City or Town, State <b>Greer, S. Carolina</b>
	21. Signature of Funeral Service Licensee  <b>M00335</b>		22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850</b>		
Physician /Medical Examiner	23a. Pertinent disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. PRIMARY LATERAL SCLEROSIS</b> Due to (or as a consequence of):  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. INDEF</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.				Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
Medical Certification: To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
	28e. Piece of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how Injury occurred		
	28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		
	29b. Signature and title of certifier 		29c. License number <b>07099</b>		29d. Date signed (Month, Day, Year) <b>August 13, 1996</b>
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Francis C. Mayle M.D. 10215 Fernwood Road #301 Bethesda, Maryland 20817</b>				
	31. Date filed (Month, Day, Year) <b>AUG 16 1996</b>		32. Registrar's Signature 		

Baltimore, Maryland 21215-0020

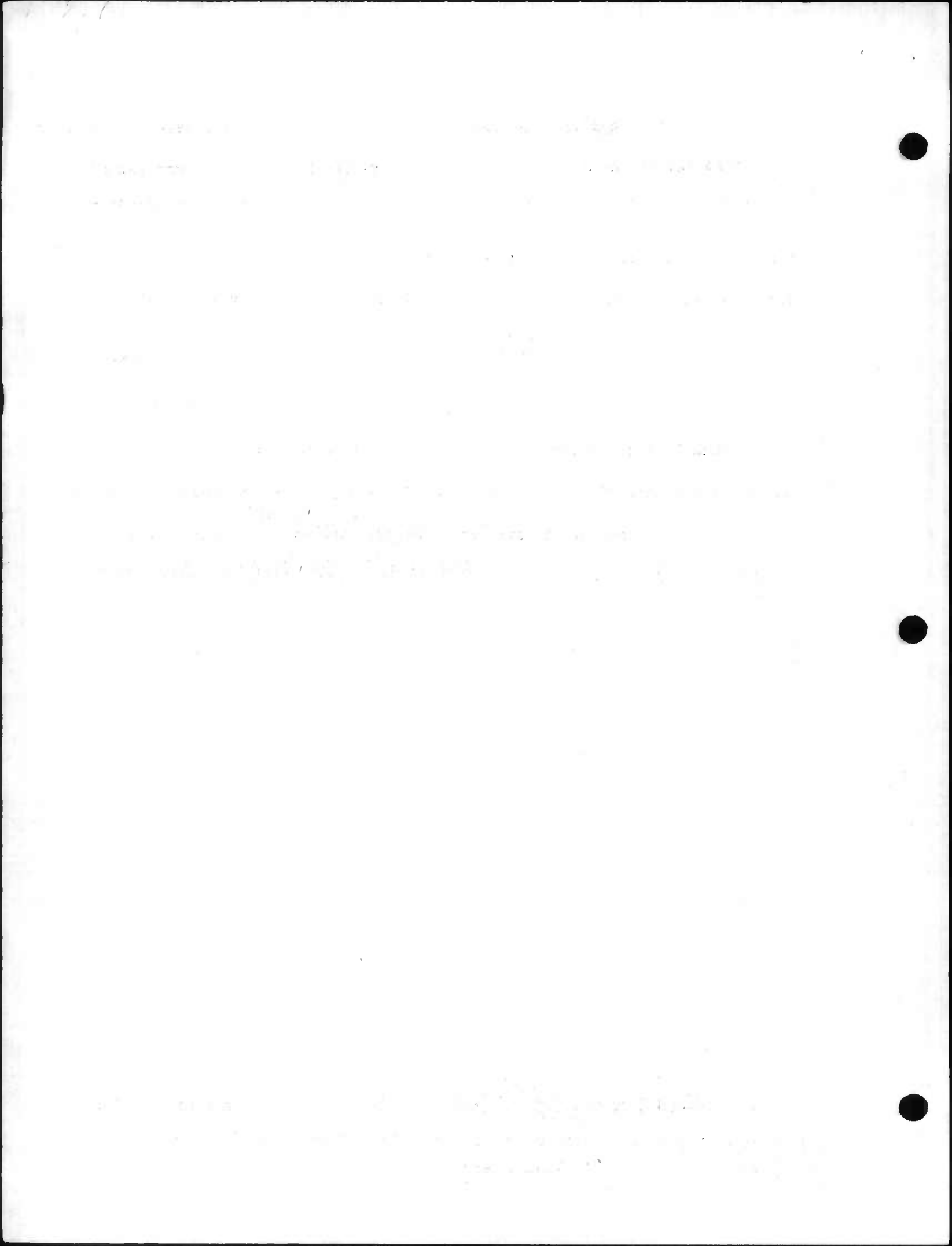
Division of Vital Records, P.O. Box 68760,

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25585

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ELLA L. OLAND

2. Date of Death

Month Day Year  
AUGUST 20 1996

3. Time of Death

7:40 AM

4a. Facility Name (If not institution, give street and number)

22000 GEORGIA AVENUE

4b. City, Town, or Location of Death

BROOKEVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

217-46-9756

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
MARCH 24, 1906

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

BROOKEVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

22000 GEORGIA AVENUE

10f. Zip Code

20833

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

WILLIAM ROYER

18. Mother's Name (First, Middle, Maiden Surname)

ROSE GAGE

19a. Informant's Name/Relationship (Type, Print)

WILLIAM F. OLAND /SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3120 DAMASCUS ROAD, BROOKEVILLE, MD, 20833

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

LAYTONSVILLE CEMETERY

Date

8/22

20c. Location - City or Town, State

LAYTONSVILLE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

MORTEL H. BARBER FUNERAL HOME

P.O. BOX 5038, LAYTONSVILLE, MD. 20882

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Coronary Artery Disease  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Breast Cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D14057

29d. Date signed (Month, Day, Year)

AUGUST 20 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lewis Kellert, M.D., 4000 Olney Laytonsville Rd., Olney, Md. 20832

31. Date filed (Month, Day, Year)

AUG 27 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25586

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Frank M. O'Connor

2. Date of Death

Month Day Year  
August 11, 1996

3. Time of Death

1:00 pm

4a. Facility Name (If not institution, give street and number)

Genesis Elder Care

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

027-30-2046

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 9, 1909

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14400 Homecrest Road

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: Unknown

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Physician

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

Martin O'Connor

18. Mother's Name (First, Middle, Maiden Surname)

Mary Unknown

19e. Informant's Name/Relationship (Type, Print)

Mary O'Connor

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14400 Homecrest Road, Silver Spring, MD 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Newton Centre

Date

8/16/96 Newton Centre, MA

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

William L. Byrd

22. Name and Address of Facility

Francis J. Collins  
Funeral Home, Inc. 500 University Blvd. West  
Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Gastric Carcinoma

Due to (or as a consequence of):

b. Metastatic Melanoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Left Cerebral Vascular Accident

Diabetes Mellitus

Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 8 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Wilkinson J. Ninala

29c. License number

D45285

29d. Date signed (Month, Day, Year)

August 12, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wilkinson J. Ninala, M.D., 18111 Prince Philip Dr. Olney, MD 20832

31. Date filed (Month, Day, Year)

AUG 13 1996

32. Registrar's Signature

John Davidson-Rodella

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



96-4213-037

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

CIP ITEMS: 23 PART I, 27, 28a-f, PER MEO

State of Maryland / Department of Health and Mental Hygiene

96 25588

FILM G-738 8/30/96 t.t

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

STEPHEN

OLUJIDE

OLOWU

2. Date of Death

Month JULY Day 28, Year 1996

3. Time of Death

5:45 PM

4a. Facility Name (If not institution, give street and number)

THOMAS ROAD

4b. City, Town, or Location of Death

ST. GEORGES ISLAND

4c. County of Death

ST. MARY'S

Funeral  
Director

5. Social Security Number

218-08-9714

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

37 35 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) Nov. 14, 1960

9. Birthplace (State or Foreign Country)

Nigeria

Usual Residence of Decedent

10a. State

Maryland

10b. County

ARROOSTOOK

10c. City, Town or Location

Presque Isle

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2 Old State Park Road

10f. Zip Code

04769

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Doctor

16b. Kind of Business/Industry

Medicine

17. Father's Name (First, Middle, Last)

Jonathan Olowu

18. Mother's Name (First, Middle, Maiden Surname)

Carol Ann Custer

19a. Informant's Name/Relationship (Type, Print)

David Olowu/ Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14900 Windmill Terrace, Silver Spring, Maryland 20905

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

8/10/96

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hines-Rinaldi Funeral Home  
11800 New Hampshire Avenue  
Silver Spring, Maryland 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. GUNSHOT WOUND OF CHEST

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☒ Homicide5 ☒ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

FOUND 7/28/96

28b. Time of

FOUND 2:22 PM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

SUBJECT WAS SHOT

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

SUMMER RESIDENCE

28f. Location (Street and Number or Rural Route Number, City or Town, State)

ST. MARY'S COUNTY MARYLAND

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► Mountaineer One Health

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JULY 29, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAYPARKS D. KOSZCZAK 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 12 1996

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25587

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RUTH M OATES

2. Date of Death

Month Day Year  
AUGUST 7, 1996

3. Time of Death

3:08 pm

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

220-12-3631

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 15, 1923

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Beltsville

10d. Inside City Limits

☐ Yes ☒ No

10a. Street and Number

11328 Cherry Hill Road Apt. 201

10f. Zip Code

20705

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John K. Magee

18. Mother's Name (First, Middle, Maiden Surname)

Mary F. Jones

19a. Informant's Name/Relationship (Type, Print)

Elizabeth L. Burroughs

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2209 Falling Creek Road Silver Spring, Maryland 20904

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery 8/10/96 Brentwood, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

► *Steven D Strand*

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W. Sil. Spr., Maryland 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. *Cerebrovascular Accident*

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *Coronary artery disease*

Due to (or as a consequence of):

c. *pulmonary fibrosis*

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

26. Place of Death (Check only one)

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier

M.D. *[Signature]*

29c. License number

D42222

29d. Date signed (Month, Day, Year)

Aug 8th 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. CHOUDRY M.D. 11119 Rockville Pike Rockville MD 20850

State  
Registrar

31. Date filed (Month, Day, Year)

AUG 12 1996

32. Registrar's Signature

*[Signature]*

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25589

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mildred Louise Parkinson</b>				2. Date of Death Month Day Year <b>August 9, 1996</b>		3. Time of Death <b>4:43 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Holy Cross Hospital</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>232-32-5604</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>69</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan. 11, 1927</b>	
	9. Birthplace (State or Foreign Country) <b>West Virginia</b>		10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Adelphi</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Maryland</b>				10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Adelphi</b>	
	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <b>1428 Ruatan Street</b>		10f. Zip Code <b>20783</b>	
	10g. Citizen of What Country? <b>U.S.A.</b>				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Clerk</b>				16b. Kind of Business/Industry <b>Federal Government</b>		17. Father's Name (First, Middle, Last) <b>John W. Shade</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>Josephine R. High</b>				19a. Informant's Name/Relationship (Type, Print) <b>Peggy L. Kuhn</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9474 White Spring Way Columbia, Maryland 21046</b>	
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		20c. Date <b>8/9/96</b>	
	20d. Location - City or Town, State <b>Alexandria, Virginia</b>				21. Signature of Funeral Service Licensee <b>Robert E. Ramsey</b>		22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., Maryland 20901</b>	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Lung cancer</b>				23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Were an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and Title of certifier <b>David A. Bloss MD</b>		
29c. License number <b>023911</b>				29d. Date signed (Month, Day, Year) <b>August 9, 1996</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David A. Bloss MD 9410 Old Georgetown Rd. Bethesda, Md, 20814</b>		
31. Date filed (Month, Day, Year) <b>AUG 12 1996</b>				32. Registrar's Signature <b>John Davidson-Randall</b>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 25590

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Chester H. Page</b>				2. Date of Death Month <b>August</b> Day <b>7</b> Year <b>1996</b>		3. Time of Death <b>7:00PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>6324 Morning Time Lane</b>				4b. City, Town, or Location of Death <b>Columbia</b>		4c. County of Death <b>Howard</b>	
Funeral Director	5. Social Security Number <b>218-34-6740</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>83</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov. 13, 1912</b>	
	9. Birthplace (State or Foreign Country) <b>Rhode Island</b>		10a. State <b>Maryland</b>		10b. County <b>Howard</b>		10c. City, Town or Location <b>Columbia</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>6324 Morning Time Lane</b>		10f. Zip Code <b>21044</b>	
	10g. Citizen of What Country? <b>United States</b>		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16. Kind of Business/Industry <b>National Bureau Of Standards</b>		17. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Electrical Engineer</b>	
	18. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Electrical Engineer</b>		19. Father's Name (First, Middle, Last) <b>Frank A. Page</b>		20. Mother's Name (First, Middle, Maiden Surname) <b>Anna Hall</b>		21. Informant's Name/Relationship (Type, Print) <b>Cindy Carter/Daughter</b>	
	22. Informant's Name/Relationship (Type, Print) <b>Cindy Carter/Daughter</b>		23. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6324 Morning Time Lane Columbia, Md. 21044</b>		24. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		25. Place of Disposition (Name of cemetery, crematory or other place) <b>Fort Lincoln Crematory</b>	
	26. Date <b>08/09/96</b>		27. Location - City or Town, State <b>Brentwood, Maryland</b>		28. Signature of Funeral Service Licensee <i>Thomas Guyon</i>		29. Name and Address of Facility <b>Hines/Rinaldi Funeral Home 11800 New Hampshire Ave. Silver Spring, Md. 20904</b>	
	23a. Part i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Lymphoma</b>		23b. Part ii. Other significant conditions contributing to death but not resulting in the underlying causa given in Part i.		23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		23d. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	23e. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Place of Death (Check only one) Hospital: <input type="checkbox"/> inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	26. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		27. Date of injury (Month, Day, Year) <b>Aug 12 1996</b>		28. Time of injury <b>M</b>		29. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28b. Location (Street and Number or Rural Route Number, City or Town, State)		29. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Kenneth M. M... MD</i>	
29c. License number <b>033686</b>		29d. Date signed (Month, Day, Year) <b>8/9/96</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Kenneth M. M... MD 18111 Prince Phillip Dr Suite 327</b>		31. Date filed (Month, Day, Year) <b>AUG 12 1996</b>		
32. Registrar's Signature <i>F... Davidson-Rodella</i>		32. Registrar's Signature <i>O'Neary MD 20832</i>		32. Registrar's Signature <i>O'Neary MD 20832</i>		32. Registrar's Signature <i>O'Neary MD 20832</i>		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Physician  
/Medical  
Examiner

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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



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State of Maryland / Department of Health and Mental Hygiene

96 25591

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>STANLEY PALFREY</b>				2. Date of Death Month <b>AUG</b> Day <b>7</b> Year <b>96</b>		3. Time of Death <b>11-53AM</b>													
	4a. Facility Name (If not institution, give street and number) <b>Laurel Regional Hospital</b>				4b. City, Town, or Location of Death <b>Laurel</b>		4c. County of Death <b>Prince George's</b>													
Funeral Director	5. Social Security Number <b>578-05-4106</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>89</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 3, 1907</b>	9. Birthplace (State or Foreign Country) <b>Ireland</b>												
	Usual Residence of Decedent																			
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Beltsville</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
	10e. Street and Number <b>3596 Powder Mill Road</b>				10f. Zip Code <b>20705</b>		10g. Citizen of What Country? <b>United States</b>													
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>													
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Plasterer</b>		16b. Kind of Business/Industry <b>Construction</b>													
	17. Father's Name (First, Middle, Last) <b>Stanley A. Palfrey, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Isabella Lindsay</b>															
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Evelyn F. Palfrey (wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>same as #10</b>															
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>George Washington Cemetery</b>		Data <b>8/11/1996</b>		20c. Location - City or Town, State <b>Adelphi, Maryland</b>													
	21. Signature of Funeral Service Licensee <b>Donald V. Borgwardt</b>				22. Name and Address of Facility <b>Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705</b>															
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
	<table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>SEPTICEMIA</b></td> <td>Approximate Interval Between Onset and Death <b>3 DAYS</b></td> </tr> <tr> <td>b.</td> <td><b>PNEUMONITIS</b></td> <td><b>30 DAYS</b></td> </tr> <tr> <td>c.</td> <td><b>CONGESTIVE HEART FAILURE</b></td> <td><b>1 YR</b></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>SEPTICEMIA</b>	Approximate Interval Between Onset and Death <b>3 DAYS</b>	b.	<b>PNEUMONITIS</b>	<b>30 DAYS</b>	c.	<b>CONGESTIVE HEART FAILURE</b>	<b>1 YR</b>	d.	
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>SEPTICEMIA</b>	Approximate Interval Between Onset and Death <b>3 DAYS</b>																	
	b.	<b>PNEUMONITIS</b>	<b>30 DAYS</b>																	
	c.	<b>CONGESTIVE HEART FAILURE</b>	<b>1 YR</b>																	
	d.																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DIABETES MELLITUS</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown														
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred												
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>V. Singh</b> <b>Attn: Phys</b>		29c. License number <b>D19897</b>		29d. Date signed (Month, Day, Year) <b>8 7 96</b>														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>V. SINGH 7209 A HANOVER PARKWAY GREENBELT MD 20770</b>																				
31. Date filed (Month, Day, Year) <b>AUG 12 1996</b>		32. Registrar's Signature <b>John Davidson-Randall</b>																		

Baltimore, Maryland 21215-0020

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Physician  
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Examiner

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State  
Registrar



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Amended #1, 4b, 8/13/96, State of Maryland / Department of Health and Mental Hygiene 96 25592  
MRT, Montg. Cty. **Certificate of Death**

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Luis B. Perillan</b> <b>LUIS PERILLAN</b>					2. Date of Death Month <b>8</b> Day <b>9</b> Year <b>96</b>		3. Time of Death <b>820pm</b>			
	4a. Facility Name (If not institution, give street and number) <b>15232 DUFFIE DRIVE</b>					4b. City, Town, or Location of Death <b>GAITHERSBURG</b>		4c. County of Death <b>Montgomery</b>			
<b>Funeral Director</b>	5. Social Security Number <b>213-39-5825</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>54</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>June 4, 1942</b>		9. Birthplace (State or Foreign Country) <b>Spain</b>		
	Usual Residence of Decedent										
10a. State <b>Maryland</b>			10b. County <b>Montgomery</b>			10c. City, Town or Location <b>Gaithersburg</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>15232 Duffie Drive</b>					10f. Zip Code <b>20878</b>			10g. Citizen of What Country? <b>Spain</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>10</b>					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Regional Manager</b>			16b. Kind of Business/Industry <b>Telecommunications Engineering</b>			
17. Father's Name (First, Middle, Last) <b>Rutilio Perillan</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Trinidad Blanco</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Dolores G. Perillan</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same as 10</b>						
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory</b>			Date <b>8-10-96</b>		20c. Location - City or Town, State <b>Beltsville, Maryland</b>			
21. Signature of Funeral Service Licensee <b>Eileen H. Rapp</b>					22. Name and Address of Facility <b>Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. HEMORRHAGE</b> Due to (or as a consequence of): <b>b. CARCINOMA OF THE LARYNX</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier <b>Paul Corn MD</b>					29c. License number <b>N9710</b>			29d. Date signed (Month, Day, Year) <b>8/10/96</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. PAUL CORN 600 NORTH WOLFE ST, BALTIMORE, MD 21287</b>											
31. Date filed (Month, Day, Year) <b>AUG 13 1996</b>			32. Registrar's Signature <b>Julia Robinson-Rodella</b>								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25593

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM D. QUANDER 111				2. Date of Death Month Aug. Day 13 Year 1996		3. Time of Death 2:30P.M.	
	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 577 20 8628		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) April 1, 1920	
	9. Birthplace (State or Foreign Country) Washington, D.C.		10a. State 10b. County 10c. City, Town or Location Washington, D.C.		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number 4510 - 14th St., N.W.				10f. Zip Code 20011		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW2		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Painter		16b. Kind of Business/Industry U.S. Government	
	17. Father's Name (First, Middle, Last) William D. Quandar 11				18. Mother's Name (First, Middle, Maiden Surname) Sara Allen			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Betty E. Quandar				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4510 - 14th St., N.W., Washington, D.C. 20011			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland National Mem. 8/17/96		20c. Location - City or Town, State Laurel, MD.			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Herbert E. Henth</i>				22. Name and Address of Facility McGuire Funeral Service Inc. 7400 Georgia Ave., N.W., Wash., D.C. 20012			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. adult respiratory distress syndrome Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							Approximate interval Between Onset and Death 30-60 min
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. chronic obstructive pulmonary disease renal insufficiency							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier David A. Garcia, M.D.				29c. License number D50367		29d. Date signed (Month, Day, Year) 8/13/96	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID A. GARCIA, MD HOLY CROSS HOSPITAL							
State Registrar	31. Date filed (Month, Day, Year) AUG 15 1996				32. Registrar's Signature <i>Davidson R. Riddell</i>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner









Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25595

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN ALFRED Rochester				2. Date of Death Month Day Year August 11 1996		3. Time of Death 3:20am	
	4a. Facility Name (If not institution, give street and number) Memorial Hospital at Easton				4b. City, Town, or Location of Death Easton		4c. County of Death Talbot	
Funeral Director	5. Social Security Number 214-32-1707		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 64 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 22, 1931	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Queen Annes		10c. City, Town or Location Church Hill	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 102 Green Street P.O. Box 144		10f. Zip Code 21623		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver		16b. Kind of Business/Industry Preston Trucking		17. Father's Name (First, Middle, Last) Conrad Asbury Rochester	
	18. Mother's Name (First, Middle, Maiden Surname) Mary Virginia Adams		19a. Informant's Name/Relationship (Type, Print) Janet Douglas Rochester- Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 Green Street, Church Hill, Md. 21623		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Rochester Memorial Garden		20c. Date 8/15/96		20d. Location - City or Town, State Ingleside, Md.		21. Signature of Funeral Service Licensee 	
	22. Name and Address of Facility Bennie Smith Funeral Home P.O. Box 1687, Easton, Md. 21601		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <u>bullous emphysema</u> Due to (or as a consequence of): b. <u>pulmonary hypertension</u> Due to (or as a consequence of): c. <u>prostate cancer</u> Due to (or as a consequence of): d. <u>hypertension</u>		Approximate Interval Between Onset and Death 1 year 1 year 1 year years		23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	29b. Signature and title of certifier 		29c. License number D 47627		29d. Date signed (Month, Day, Year) 8-11-96		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kathleen Hoey, MD, North Liberty Street, Centreville, Md. 21617	
State Registrar	31. Date filed (Month, Day, Year) AUG 14 1996		32. Registrar's Signature 		33. Registrar's Title Registrar		34. Registrar's Address Baltimore, Maryland 21215-0020	

1. The first part of the document is a list of names and addresses.

2. The second part of the document is a list of names and addresses.

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96-4455-031

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

96 25596

ITEMS: 23 PART I, 27, PER MED

State of Maryland / Department of Health and Mental Hygiene

FILM g-739 9/6/96 t.t

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FRANCIS MARION ROBERTS</b>		2. Date of Death Month Day Year <b>AUGUST 7 1996</b>		3. Time of Death <b>6:16 P.M.</b>
	4a. Facility Name (If not institution, give street and number) <b>5402 TUSCARAWAS ROAD</b>		4b. City, Town, or Location of Death <b>BETHESDA</b>		4c. County of Death <b>MONTGOMERY</b>
Funeral Director	5. Social Security Number <b>046-20-6904</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>69</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Jan. 17, 1927</b>		9. Birthplace (State or Foreign Country) <b>New York</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>
	10c. City, Town or Location <b>Bethesda</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>5402 Tuscarawas Road</b>		10f. Zip Code <b>20816-3125</b>		10g. Citizen of What Country? <b>United States</b>
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>World War II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>5+</b>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Anthropologist / Musician</b>		16b. Kind of Business/Industry <b>Self Employed</b>		
	17. Father's Name (First, Middle, Last) <b>Arthur Sidney Roberts</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Greene</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Walter W. Roberts / brother</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5402 Tuscarawas Road, Bethesda, Maryland 20816-3125</b>		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Montgomery Crematorium, Inc.</b>		20c. Location - City or Town, State <b>Bethesda, Maryland</b>
	21. Signature of Funeral Service Licensee <b>Barbara J. McMillen Lawrence</b>		22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b>				
	Due to (or as a consequence of): <b>ASTHMA</b>				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how Injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>Donald G. Wright MD</b>		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 9, 1996</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>AUG 12 1996</b>		32. Registrar's Signature <b>John Davidson-Randall</b>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene 96 25597

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) William A. Ross

2. Date of Death Month Day Year August 11, 1996

3. Time of Death 9:45 p.

Funeral  
Director

4a. Facility Name (If not institution, give street and number) 11807 Ellington Drive

4b. City, Town, or Location of Death Beltsville

4c. County of Death Prince Georges

5. Social Security Number 219-12-3880

6. Sex ☒ M ☐ F

7. Age (In yrs. last birthday) 73 Yrs.

8. Date of Birth (Month, Day, Year) Apr. 26, 1923

9. Birthplace (State or Foreign Country) Maryland

Usual Residence of Decedent

10a. State MD

10b. County Pr. Georges

10c. City, Town or Location Beltsville

10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number 11807 Ellington Drive

10f. Zip Code 20705

10g. Citizen of What Country? U.S.A.

11. Marital Status ☐ Never Married ☒ Married ☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? ☒ Yes ☐ No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 yrs

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk

16b. Kind of Business/Industry Veterans Admin.

17. Father's Name (First, Middle, Last) John Ross

18. Mother's Name (First, Middle, Maiden Surname) Henrietta Crump

19a. Informant's Name/Relationship (Type, Print) Mary W. Ross (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10387 N. Cherry Dr., Kansas City, MO 64155

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cem.

20c. Location - City or Town, State Silver Spring, MD

20d. Date 8/17/96

21. Signature of Funeral Service Licensee [Signature]

22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) coronary Artery disease

Due to (or as a consequence of): Atherosclerosis

Due to (or as a consequence of): Hyperlipidemia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death 3 years several years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Carcinoma Prostate Depression Hypertension

23b. Did tobacco use contribute to the cause of death? ☐ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed? ☐ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☐ No

25. Was case referred to medical examiner? ☐ Yes ☒ No

26. Place of Death (Check only one) Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? ☐ Yes ☒ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier V. P. Chander MD

29c. License number D 16380

29d. Date signed (Month, Day, Year) Aug 14, 96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V. Prem Chandar 6001 Landover Rd. Cheverly, MD

31. Date filed (Month, Day, Year) AUG 15 1996

32. Registrar's Signature [Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25598

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>RONALD COLEMAN ROSS</b>				2. Date of Death Month <b>AUG</b> Day <b>9</b> Year <b>96</b>		3. Time of Death <b>0619</b>	
	4a. Facility Name (If not institution, give street and number) <b>Holy Cross Hospital</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>217-30-6780</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>62</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Feb. 15, 1934</b>	9. Birthplace (State or Foreign Country) <b>Wash. DC</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>12002 Colin Road</b>				10f. Zip Code <b>20906</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1956-58</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Maintenance Engineer</b>		16b. Kind of Business/Industry <b>None</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Alfred Ross</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Annie Gross</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Patricia Hamilton (Daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12002 Colin Rd., Silver Spring, MD 20906</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Ash Memorial Cemetery</b>		20c. Location - City or Town, State <b>8/14/96 Sandy Spring, MD</b>			
	21. Signature of Funeral Service Licensee <i>George R. Snowden</i>		22. Name and Address of Facility <b>SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>MYOCARDIAL INFARCTION</b> Due to (or as a consequence of):							Approximate Interval Between Onset and Death
	b. Due to (or as a consequence of):							
	c. Due to (or as a consequence of):							
	d. Due to (or as a consequence of):							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier <i>Francis C. Mayle</i>		29c. License number <b>007099</b>		29d. Date signed (Month, Day, Year) <b>AUG 9 96</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>FRANCIS C. MAYLE 10215 FERNWOOD RD BETHESDA MD 20817</b>							
	31. Date filed (Month, Day, Year) <b>AUG 14 1996</b>		32. Registrar's Signature <i>John Davidson-Randall</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

1. The first part of the paper is devoted to a general discussion of the problem of the existence of solutions of the system of equations

which are satisfied by the functions  $u_i(x, y, z)$  and  $v_i(x, y, z)$  in the domain  $D$  of the space  $E_3$ .

2. In the second part of the paper the author considers the case when the functions  $u_i$  and  $v_i$  are assumed to be harmonic in the domain  $D$ .

3. In the third part of the paper the author considers the case when the functions  $u_i$  and  $v_i$  are assumed to be biharmonic in the domain  $D$ .

4. In the fourth part of the paper the author considers the case when the functions  $u_i$  and  $v_i$  are assumed to be triharmonic in the domain  $D$ .

5. In the fifth part of the paper the author considers the case when the functions  $u_i$  and  $v_i$  are assumed to be tetraharmonic in the domain  $D$ .

6. In the sixth part of the paper the author considers the case when the functions  $u_i$  and  $v_i$  are assumed to be pentaharmonic in the domain  $D$ .

7. In the seventh part of the paper the author considers the case when the functions  $u_i$  and  $v_i$  are assumed to be hexaharmonic in the domain  $D$ .

8. In the eighth part of the paper the author considers the case when the functions  $u_i$  and  $v_i$  are assumed to be heptaharmonic in the domain  $D$ .

9. In the ninth part of the paper the author considers the case when the functions  $u_i$  and  $v_i$  are assumed to be octaharmonic in the domain  $D$ .

10. In the tenth part of the paper the author considers the case when the functions  $u_i$  and  $v_i$  are assumed to be nonaharmonic in the domain  $D$ .

11. In the eleventh part of the paper the author considers the case when the functions  $u_i$  and  $v_i$  are assumed to be decaharmonic in the domain  $D$ .

12. In the twelfth part of the paper the author considers the case when the functions  $u_i$  and  $v_i$  are assumed to be undecaharmonic in the domain  $D$ .

13. In the thirteenth part of the paper the author considers the case when the functions  $u_i$  and  $v_i$  are assumed to be duodecapharmonic in the domain  $D$ .

14. In the fourteenth part of the paper the author considers the case when the functions  $u_i$  and  $v_i$  are assumed to be tridecapharmonic in the domain  $D$ .

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State of Maryland / Department of Health and Mental Hygiene

96 25599

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>EUGENE MAYNARD READING</b>				2. Date of Death Month <b>AUG</b> Day <b>15</b> Year <b>1996</b>		3. Time of Death <b>3:45PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Holy Cross Hospital</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>		
Funeral Director	5. Social Security Number <b>146-10-8562</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>81</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov. 7, 1914</b>		
	9. Birthplace (State or Foreign Country) <b>New Jersey</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>		
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>402 Torrington Place</b>		10f. Zip Code <b>20901</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Building Engineer</b>		16b. Kind of Business/Industry <b>NASA</b>					
17. Father's Name (First, Middle, Last) <b>Raymond A. Reading</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ada M. Hendricks</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Dorothy F. Reading</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>402 Torrington Place, Silver Spring, MD 20901</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Sandy Ridge Cemetery</b>		Date <b>8/19/96</b>		20c. Location - City or Town, State <b>Stockton, New Jersey</b>			
21. Signature of Funeral Service Licensee <b>Eric S. Scurbo</b>				22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901</b>					
23a. Part I. Entail the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Severe Aspiration Pneumonia</b> Due to (or as a consequence of): b. <b>Stroke</b> Due to (or as a consequence of): c. <b>Alcohol Abuse (chronic)</b> Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>2 wks.</b> <b>2 wks.</b> <b>years</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>D.ube Res.</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No			
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Charmen Kershtey</b>		29c. License number <b>038435</b>		29d. Date signed (Month, Day, Year) <b>8/16/96</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>10313 Georgia Ave. Suite 37, Silver Spring, MD</b>									
31. Date filed (Month, Day, Year) <b>AUG 16 1996</b>		32. Registrar's Signature <b>Davidson</b>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

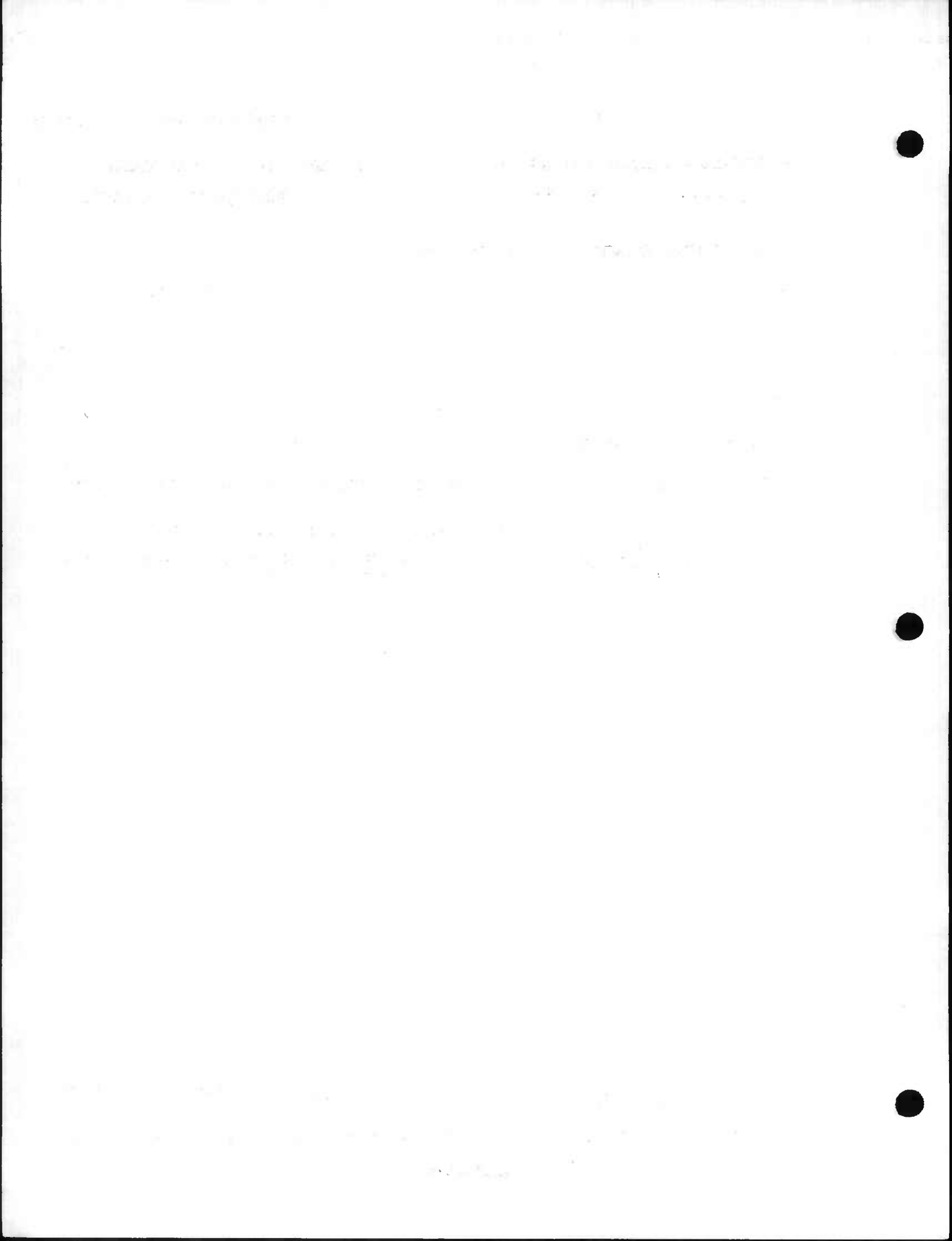
State of Maryland / Department of Health and Mental Hygiene

96 25600

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROZA RADAN				2. Date of Death Month Day Year AUGUST 13, 1996				3. Time of Death 11:20 PM	
	4a. Facility Name (If not Institution, give street and number) SPRINGBROOK ADVENTIST NURSING HOME				4b. City, Town, or Location of Death SILVERSPRING				4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 213 42 8672		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) JUNE 4, 1911		9. Birthplace (State or Foreign Country) CROATIA	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD.		10b. County PRINCE GEORGES		10c. City, Town or Location TAKOMA PARK				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 6613 GUDE AVE.				10f. Zip Code 20912		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER				16b. Kind of Business/Industry HOUSEWIFE			
	17. Father's Name (First, Middle, Last) IVAN SARIC				18. Mother's Name (First, Middle, Maiden Surname) STOJO ZEKIC					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) VENKA LOEHE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20878 209 RIDGE POINT PLACE, GAITHERSBURG, MD					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) GEORGE WASHINGTON CEM.		Date AUG. 16, 1996		20c. Location - City or Town, State ADELPHI, MD.	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility TAKOMA FUNERAL HOME INC 254 CARROLL ST N.W. WASHINGTON, D.C. 20012					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <i>Pneumonia</i> Due to (or as a consequence of): b. <i>Mesothelioma left lung</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <i>1 year</i>									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Colon cancer</i>									
State Registrar	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 				29c. License number 108089				29d. Date signed (Month, Day, Year) AUGUST 15, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL LEIBOWITZ, M.D. 11120 NEW HAMPSHIRE AVE., SILVER SPRING, MD.										
31. Date filed (Month, Day, Year) AUG 15 1996				32. Registrar's Signature 						





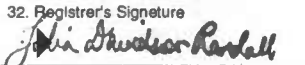
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State of Maryland / Department of Health and Mental Hygiene

96 25601

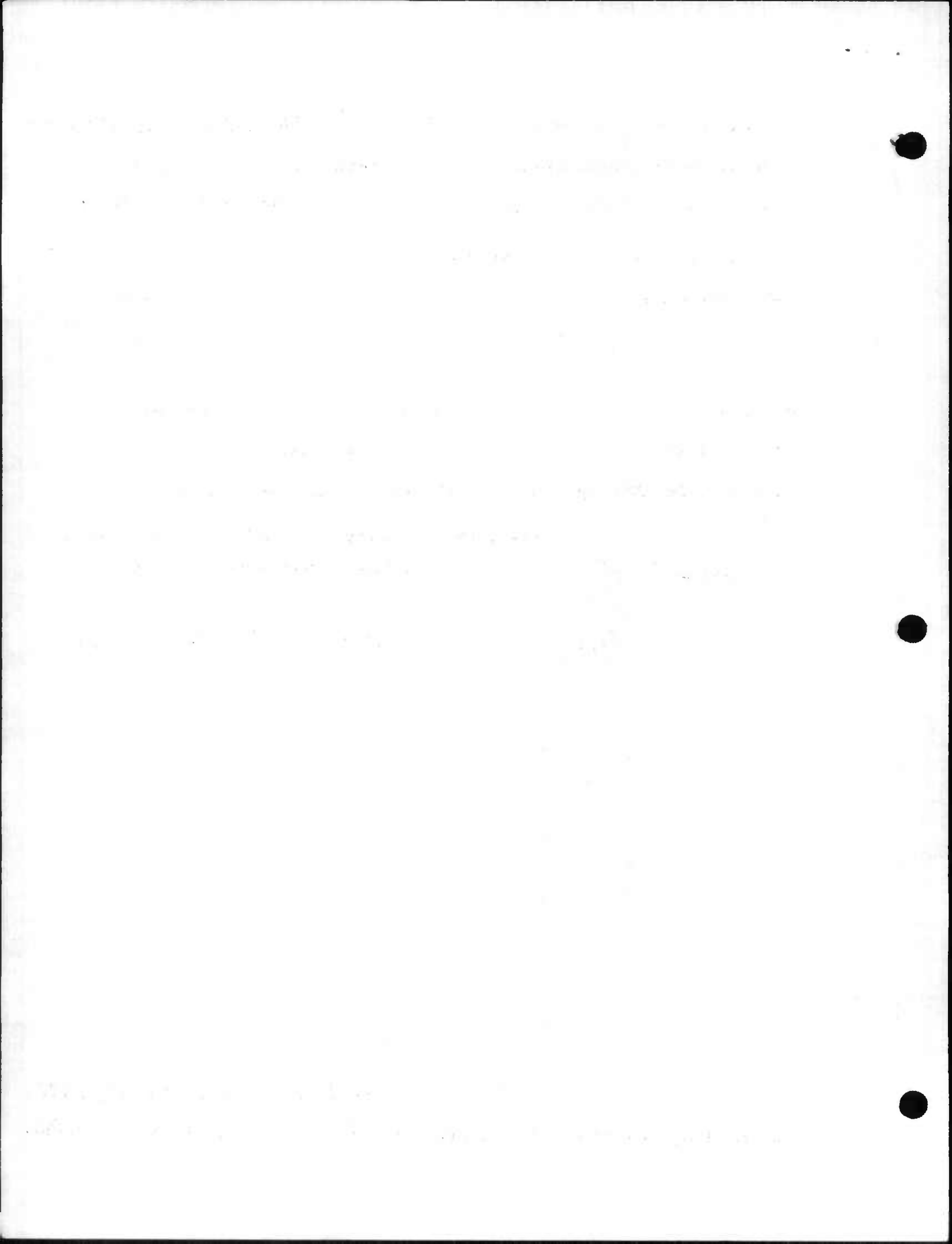
## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CATHERINE ELIZABETH RAUSCHENBERG</b>		2. Date of Death Month <b>AUGUST</b> Day <b>13</b> Year <b>1996</b>		3. Time of Death <b>10:45AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Carroll County General Hospital</b>		4b. City, Town, or Location of Death <b>Westminster</b>		4c. County of Death <b>Carroll</b>	
Funeral Director	5. Social Security Number <b>214-18-0356</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>75</b> Yrs.	
	8. Date of Birth (Month, Day, Year) <b>Jan. 26, 1921</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>			
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Woodbine</b>	
	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>6951 John Pickett</b>		10f. Zip Code <b>21797</b>	
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7th grade</b> College (1-4or 5+) <b>Housewife</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Own Home</b>	
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Frank Plotzke</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Eva Zilich</b>		19. Informant's Name/Relationship (Type, Print) <b>Mr. Carl H. Rauschenberg (Husband)</b>	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Rauschenberg Cemetery</b>		20c. Location - City or Town, State <b>8/16/96 Woodbine, Maryland</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Burrier-Queen Funeral Directors, Inc. 1212 W. Old Liberty Road Winfield, MD 21784</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Immediate Cause (Final disease or condition resulting in death)</b> <b>a. METASTATIC COLON CANCER</b> Due to (or as a consequence of): <b>b.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D46962</b>	
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) <b>AUGUST 13, 1996.</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>M. SHIRAZI, MD. HOUSE PHYSICIAN. CARROLL COUNTY GENERAL HOSPITAL.</b>		31. Date filed (Month, Day, Year) <b>AUG 16 1996</b>	
	32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25602

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Clifford E. Ralkey

2. Date of Death

August 12, 1996

3. Time of Death

1:29 pm

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

502-36-1684

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 21, 1928

9. Birthplace (State or Foreign Country)

North Dakota

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7904 15th Avenue

10f. Zip Code

20783

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Roofer

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Daniel Ralkey

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19e. Informant's Name/Relationship (Type, Print)

Mary Ann Ralkey

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7904 15th Avenue, Hyattsville, MD 20783

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

George Washington Cemetery

Date

8/16/96

20c. Location - City or Town, State

Adelphi, Maryland

21. Signature of Funeral Service Licensee

*John L. Chubb*

22. Name and Address of Facility

Francis J. Collins  
Funeral Home, Inc. 500 University Blvd. West  
Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. *Artery thrombosis*  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. *Chronic Obstructive Lung disease*  
Due to (or as a consequence of):c. \_\_\_\_\_  
Due to (or as a consequence of):d. \_\_\_\_\_  
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Degenerative Joint disease**Right hip replacement*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☒ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29e. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

*Raman Tuli*

29c. License number

D19609

29d. Date signed (Month, Day, Year)

8-14-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Raman Tuli, M.D., 10810 Darnestown Road, Gaithersburg, MD 20878

31. Date filed (Month, Day, Year)

AUG 16 1996

32. Registrar's Signature

*Davidson-Rodriguez*State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25603

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) <b>Harry Sewell</b>				2. Date of Death Month <b>August</b> Day <b>10</b> Year <b>1996</b>		3. Time of Death <b>5:35 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>The Pines</b>				4b. City, Town, or Location of Death <b>Easton</b>		4c. County of Death <b>Talbot</b>	
Funeral Director	5. Social Security Number <b>215-38-0989</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>62 Yrs.</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jul. 7, 1934</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedant							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Caroline</b>		10c. City, Town or Location <b>Ridgely</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>12710 Cow Barn Road</b>				10f. Zip Code <b>21660</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedant Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedant's Education (Specify only highest grade completed) <b>11th</b>		16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>		16b. Kind of Business/Industry <b>Lumber</b>			
	17. Father's Name (First, Middle, Last) <b>Harry D. Sewell, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ader Jones</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>David A. Sewell</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12710 Cow Barn Road, Ridgely, Md. 21660</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Roosevelt Cemetery</b>		Date <b>8/15/96</b>		20c. Location - City or Town, State <b>Centreville, Md.</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Bennie Smith Funeral Home P.O. Box 1687, Easton, Md. 21601</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. METASTATIC PROSTATE CANCER</b> Due to (or as a consequence of): <b>b. ANEMIA</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Approximate Interval Between Onset and Death <b>1995</b>							
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSION</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
			28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier 		29c. License number <b>H48241</b>		29d. Date signed (Month, Day, Year) <b>8/12/96</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DANIEL E. MAYAS, DO 508 FIDLEWILD AVE EASTON, MD 21601</b>							
	31. Date filed (Month, Day, Year) <b>AUG 13 1996</b>		32. Registrar's Signature 					



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Edna Eugenia SHEETENHELM				2. DATE OF DEATH MONTH DAY YEAR August 11, 1996		3. TIME OF DEATH 11:20am M	
4. SOCIAL SECURITY NUMBER 217-56-1198		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug 16, 1914	
8. BIRTHPLACE (State or Foreign Country) Maryland		9a. FACILITY NAME (If not institution, give street and number) Vindabona Nursing Center		9b. CITY, TOWN OR LOCATION OF DEATH Braddock Heights		9c. COUNTY OF DEATH Frederick	
10a. STATE Maryland				10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Frederick	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 750 Parkview Apts		10f. ZIP CODE 21701	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				16b. KIND OF BUSINESS/INDUSTRY Own Home		17. FATHER'S NAME (First, Middle, Last) Robert L CRAMER	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Edna Ayres Wright				19a. INFORMANT'S NAME (Type/Print) W. Jerome Offutt, Administrator		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 West Second Street, Frederick, Maryland 21701	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Olivet Cemetery Aug 15, 1996		20c. LOCATION — City or Town, State Frederick, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Keith Lynn Peterson</i> M00706				22. NAME AND ADDRESS OF FACILITY Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, MD 21701		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>ASCD</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>hypertension</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Reactive Depression, Renal Cancer metastatic to right lung, reflux esophagitis, mild Alzheimer's disease</i>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. Christopher Fleming</i>		29c. LICENSE NUMBER D37178	
29d. DATE SIGNED (Month, Day, Year) 8-12-96				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. Christopher Fleming, MD, 610 Ninth Avenue, Brunswick, Maryland 21716		31. DATE FILED (Month, Day, Year) AUG 13 1996	
32. REGISTRAR'S SIGNATURE <i>Li Anderson-Rodriguez</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DAVID M. SHAW Jr.</b>		2. Date of Death Month Day Year <b>AUGUST 23, 1996</b>		3. Time of Death <b>1220PM</b>
	4e. Facility Name (If not institution, give street and number) <b>9611 POTOMAC DRIVE</b>		4b. City, Town, or Location of Death <b>OXON HILL</b>		4c. County of Death <b>PRINCE GEORGES</b>
Funeral Director	5. Social Security Number <b>215-56-9643</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>46</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>12/23/49</b>		9. Birthplace (State or Foreign Country) <b>Wash. D.C.</b>		
Usual Residence of Decedent					
10a. State <b>Md.</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Fort Washington</b>	
10e. Street and Number <b>1617 Tucker Road</b>		10f. Zip Code <b>20744</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Salesman</b>		16b. Kind of Business/Industry <b>Automobile/ Boats</b>	
17. Father's Name (First, Middle, Last) <b>David M. Shaw Sr.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Hilda M. Chesser</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Rebecca L. Koziol/Sister</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9523 Barnstable Ct., Burke, VA. 22015</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan</b>		20c. Location - City or Town, State <b>8/24/96 Alexandria, VA.</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>George P. Kalas Funeral Home, 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. CIRRHOSIS OF LIVER</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):					Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
					24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 24, 1996</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dennis S. Chuteau 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>AUG 28 1996</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25606

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANNA PATRICIA SAMUEL				2. Date of Death Month Day Year AUGUST 09, 1996		3. Time of Death 10:49 AM	
	4e. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death	
Funeral Director	5. Social Security Number 219-04-7948		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 44 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 7, 1951	
	9. Birthplace (State or Foreign Country) Sri Lanka							
To Be Completed by Funeral Director	Usual Residence of Decedent							
	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 8009 Eastern Avenue, #302				10f. Zip Code 20910		10g. Citizen of What Country? Sri Lanka	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Sri Lankan	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrative Secretary		16b. Kind of Business/Industry World Bank			
	17. Father's Name (First, Middle, Last) Paul A. Samuel				18. Mother's Name (First, Middle, Maiden Surname) Ruth J. K. Samuel			
	19a. Informant's Name/Relationship (Type, Print) Paul & Ruth Samuel				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 Lauries Road, Colombo 4, Sri Lanka			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		Date 8-10-96		20c. Location - City or Town, State Beltsville, Maryland	
	21. Signature of Funeral Service Licensee Eileen H. Rapp				22. Name and Address of Facility Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910			
	Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. septic shock Due to (or as a consequence of) b. Cardiomyopathy Due to (or as a consequence of) c. Adult Respiratory Distress Syndrome Due to (or as a consequence of) d. Bone Marrow Transplant for Breast Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last						
Approximate Interval Between Onset and Death 4 day 2 week 2 week 3 week								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute Renal Failure								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Herbert H. Hurdwitz, MD				29c. License number D42869		29d. Date signed (Month, Day, Year) 08-09-96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HERBERT H. HURDWITZ, MD 600 North Wolfe Street Baltimore, MD 21205								
31. Date filed (Month, Day, Year) AUG 12 1996		32. Registrar's Signature Davidson-Randall						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

15



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25607

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HELEN VIRGINIA STRALEY</b>		2. Date of Death Month <b>AUG. 11</b> Day <b>11</b> Year <b>1996</b>		3. Time of Death <b>10:10PM</b>
	4a. Facility Name (If not institution, give street and number) <b>LONG VIEW NURSING HOME</b>		4b. City, Town, or Location of Death <b>MANCHESTER</b>		4c. County of Death <b>CARROLL</b>
Funeral Director	5. Social Security Number <b>220-16-0089</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>2/23/1917</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State <b>MD.</b>		10b. County <b>CARROLL</b>
	10c. City, Town or Location <b>WESTMINSTER</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>76 WINCHESTER AVE.</b>		10f. Zip Code <b>21157</b>		10g. Citizen of What Country? <b>USA.</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4or 5+) <b>HOUSEKEEPING</b>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOSPITAL</b>		16b. Kind of Business/Industry <b>HOSPITAL</b>		
	17. Father's Name (First, Middle, Last) <b>CHARLES SHERMAN</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>DAISY COLEMAN</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>JAMES E. STRALEY - SON</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4503 OAKLEIGH DR., MANCHESTER, MD. 21102</b>		
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>EVERGREEN MEM.GARDENS</b>		20c. Location - City or Town, State <b>8/14/96 FINKSBURG, MD.</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Actinobacter's Demolition</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>				Approximate Interval Between Onset and Death <b>year</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
	29b. Signature and title of certifier 		29c. License number <b>233165</b>		29d. Date signed (Month, Day, Year) <b>8/13/96</b>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Steven Shaffer MD 21140000 Pike Hanover and 21074</b>				
State Registrar	31. Date filed (Month, Day, Year) <b>AUG 14 1996</b>		32. Registrar's Signature 		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25608

Amended item #10f per F.D.  
Carroll Co. 8/16/96 P.L.C.

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>John George Schwedes</b>				2. Date of Death Month Day Year <b>08 14 96</b>		3. Time of Death <b>0520</b>
	4a. Facility Name (If not institution, give street and number) <b>Carroll County General Hospital</b>				4b. City, Town, or Location of Death <b>Westminster</b>		4c. County of Death <b>Carroll</b>
Funeral Director	5. Social Security Number <b>217-09-7131</b>	6. Sex <b>10 M 2 F</b>	7. Age (In yrs. last birthday) <b>79</b> Yrs.	If Under 1 Year Month Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>07-31-17</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>CARROLL</b>	10c. City, Town or Location <b>Mt. Airy</b>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>4821 Buffalo Rd</b>			10f. Zip Code <b>21791 21771</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Sheet Metal Worker</b>		16b. Kind of Business/Industry <b>Local Union #122</b>		
	17. Father's Name (First, Middle, Last) <b>John Schwedes</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Mamie Peregoy</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>John C. Schwedes</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4821 Buffalo Road Mt. Airy, MD 21771</b>			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) <b>Entombment</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Loudon Park Mausoleum</b>		20c. Location - City or Town, State <b>8/16/96 Baltimore, Maryland</b>		
	21. Signature of Funeral Service Licensee <b>James B. Covey</b>			22. Name and Address of Facility <b>Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, MD 21784</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>congestive heart failure</b> Due to (or as a consequence of): b. <b>coronary artery disease</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death <b>1991 (5 yrs)</b> <b>1991 (5 yrs)</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>metastatic prostate CA, embolic Arterial Occlusion @ feet, Biliary colic, cholelithiasis, organic brain syndrome, seizure disorder</b>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury <b>M</b>	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and Title of certifier <b>Thomas K. Galvin m</b>		29c. License number <b>D31660</b>		29d. Date signed (Month, Day, Year) <b>8/14/96</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>THOMAS K. GALVIN III, M.D. 295 Stonewall Avenue #104 Westminster MD 21157</b>							
31. Date filed (Month, Day, Year) <b>AUG 16 1996</b>		32. Registrar's Signature <b>John Andrew Carroll</b>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25609

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Horace Greeley Schief, Jr.

2. Date of Death

Month August Day 8 Year 1996

3. Time of Death

11:07 am

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

579-36-0222

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 2, 1928

9. Birthplace (State or Foreign Country)

Louisiana

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10213 Woodmoor Circle

10f. Zip Code

20901

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Banker

16b. Kind of Business/Industry

Banking

17. Father's Name (First, Middle, Last)

Horace G. Schief, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Martha Dulaney

19a. Informant's Name/Relationship (Type, Print)

Rita F. Schief

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10213 Woodmoor Circle, Silver Spring, MD 20901

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metropolitan Crematory

Date

8/11/96

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

▶ *Timothy G. Campbell*22. Name and Address of Facility  
Francis J. Collins Funeral  
Home, Inc. 500 University Blvd. West  
Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. *RESPIRATORY FAILURE*  
Due to (or as a consequence of):

5 YRS

b. *COPD PULMONALIS*  
Due to (or as a consequence of):

10 YRS

c. *RESTRICTIVE LUNG DISEASE*  
Due to (or as a consequence of):

40 YRS

d. *KYPHOSCOLIOSIS*

60 YRS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*BACK PAIN, SCIATICA*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

▶ *Steven T. Kariya - MD*

29c. License number

D36252

29d. Date signed (Month, Day, Year)

AUG 8, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STEVEN T. KARIYA, MD, 11501 GEORGIA AVE #515, WHEATON MD 20902

31. Date filed (Month, Day, Year)

AUG 12 1996

32. Registrar's Signature

▶ *Davidson-Randall*State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25610

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>HAROLD W. SAVAGE</i>				2. Date of Death Month <i>Aug</i> Day <i>4</i> Year <i>1996</i>		3. Time of Death <i>11:40 PM</i>										
	4a. Facility Name (If not institution, give street and number) <i>Washington Adventist Hospital</i>				4b. City, Town, or Location of Death <i>Takoma Park</i>		4c. County of Death <i>Montgomery</i>										
Funeral Director	5. Social Security Number <i>577-05-3803</i>		6. Sex <i>1 M 2 F</i>	7. Age (In yrs. last birthday) <i>82</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>Aug. 1, 1914</i>	9. Birthplace (State or Foreign Country) <i>Washington, D.C.</i>									
	Usual Residence of Decedent																
To Be Completed by Funeral Director	10a. State <i>Maryland</i>		10b. County <i>Prince Georges</i>		10c. City, Town or Location <i>College Park</i>		10d. Inside City Limits <i>1 X</i> Yes <i>2</i> No										
	10e. Street and Number <i>3519 Marlborough Way</i>				10f. Zip Code <i>20740</i>		10g. Citizen of What Country? <i>USA</i>										
	11. Marital Status <i>1</i> <input type="checkbox"/> Navar Married <i>2 X</i> <input checked="" type="checkbox"/> Married <i>3</i> <input type="checkbox"/> Widowed <i>4</i> <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <i>1 X</i> Yes <i>2</i> No If Yes, Give Year or Dates: <i>WW II</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <i>1</i> <input type="checkbox"/> Yes <i>2 X</i> <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>										
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>4</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Accountant</i>		16b. Kind of Business/Industry <i>Banking</i>										
	17. Father's Name (First, Middle, Last) <i>Audley A. P. Savage</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Winifred Austin</i>												
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <i>Nancy Savage / Wife</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3519 Marlborough Way, College Park, Maryland 20740</i>												
	20a. Method of Disposition <i>1 X</i> <input checked="" type="checkbox"/> Burial <i>2</i> <input type="checkbox"/> Cremation <i>3</i> <input type="checkbox"/> Removal from State <i>4</i> <input type="checkbox"/> Donation <i>5</i> <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Rock Creek Cemetery</i>		Data <i>8/8/96</i>		20c. Location - City or Town, State <i>Washington, D.C.</i>										
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <i>Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904</i>												
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																
	Approximate Interval Between Onset and Death																
<table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <i>Acute myocardial infarction</i></td> <td><i>5 WK</i></td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. <i>Ischemic heart disease</i></td> <td><i>Yrs</i></td> </tr> <tr> <td>c. <i>Coronary atherosclerosis</i></td> <td><i>Yrs</i></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. <i>Acute myocardial infarction</i>	<i>5 WK</i>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <i>Ischemic heart disease</i>	<i>Yrs</i>	c. <i>Coronary atherosclerosis</i>	<i>Yrs</i>	d.	
Immediate Cause (Final disease or condition resulting in death)	a. <i>Acute myocardial infarction</i>	<i>5 WK</i>															
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <i>Ischemic heart disease</i>	<i>Yrs</i>															
	c. <i>Coronary atherosclerosis</i>	<i>Yrs</i>															
	d.																
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Multi system failure, acute respiratory failure, acute renal insufficiency, Acute pulmonary edema, Severe Anaemia, altered mental status</i>						23b. Did tobacco use contribute to the cause of death? <i>1</i> <input type="checkbox"/> Yes <i>2 X</i> <input checked="" type="checkbox"/> No <i>3</i> <input type="checkbox"/> Probably <i>4</i> <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <i>1</i> <input type="checkbox"/> Yes <i>2 X</i> <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <i>1</i> <input type="checkbox"/> Yes <i>2 X</i> <input checked="" type="checkbox"/> No															
25. Was case referred to medical examiner? <i>1</i> <input type="checkbox"/> Yes <i>2 X</i> <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <i>1 X</i> <input checked="" type="checkbox"/> Inpatient <i>2</i> <input type="checkbox"/> ER/Outpatient <i>3</i> <input type="checkbox"/> DOA Other: <i>4</i> <input type="checkbox"/> Nursing Home <i>5</i> <input type="checkbox"/> Residence <i>6</i> <input type="checkbox"/> Other (Specify)															
27. Manner of Death <i>1 X</i> <input checked="" type="checkbox"/> Natural <i>5</i> <input type="checkbox"/> Pending Investigation <i>2</i> <input type="checkbox"/> Accident <i>6</i> <input type="checkbox"/> Could not be determined <i>3</i> <input type="checkbox"/> Suicide <i>4</i> <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <i>1</i> <input type="checkbox"/> Yes <i>2</i> <input type="checkbox"/> No											
28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred															
28f. Location (Street and Number or Rural Route Number, City or Town, State)																	
29a. Certifier (Check only one) <i>1 X</i> <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <i>2</i> <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																	
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <i>024720</i>		29d. Date signed (Month, Day, Year) <i>8/05/96</i>											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>RAINIER K. RUSTAGI MD 6132 LANDOVER ROAD CHEVERLY, MD 20785</i>																	
31. Date filed (Month, Day, Year) <i>AUG 12 1996</i>		32. Registrar's Signature <i>[Signature]</i>															

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25611

Amended #7, #8, 8/15/96, MRT, Montg. Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Robert S. SARRACINO

2. Date of Death

Month Day Year  
08 12 96

3. Time of Death

8 AM

4a. Facility Name (If not institution, give street and number)

Hyattsville Manor Nursing Home

4b. City, Town, or Location of Death

Hyattsville

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

207-44-1394

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

43 4 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

2-31-96

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

Dec. 31, 1953

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

6500 Riggs Road

10f. Zip Code

20783

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married  
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

Collage (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nursing Assistant

16b. Kind of Business/Industry

Nursing Home

17. Father's Name (First, Middle, Last)

Anthony Sarracino

18. Mother's Name (First, Middle, Maiden Surname)

Christina Amore

19a. Informant's Name/Relationship (Type, Print)

Marie Noble

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

305 Darby Road, Ridley Park, PA 19078

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SS Peter & Paul Cemetery

Date

8-16-96

20c. Location - City or Town, State

Marple Township, Pennsylvania

21. Signature of Funeral Service Licensee

*Eileen H. Rapp*

22. Name and Address of Facility

Rapp Funeral Services, P. A.  
933 Gist Avenue, Silver Spring, MD 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *aids*  
Due to (or as a consequence of):

b. *diabetes*  
Due to (or as a consequence of):

c. *pneumonia*  
Due to (or as a consequence of):

d. *cardiopulmonary failure*  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Anemia*

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?  
☐ Yes ☒ No

28. Place of Death (Check only one)

Hospital:

☐ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☒ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Suicide  
☐ Homicide ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Robert D Skipworth MD*

29c. License number

028906

29d. Date signed (Month, Day, Year)

August 12, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert D. Skipworth MD, 585 MAIN STREET, LAUREL, MD 20707

31. Date filed (Month, Day, Year)

AUG 15 1996

32. Registrar's Signature

*Julia Davidson-Randall*

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25612

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Phyllis Oliver Salls</b>					2. Date of Death Month <b>August</b> Day <b>10</b> , Year <b>1996</b>		3. Time of Death <b>13:39 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Montgomery General Hospital</b>					4b. City, Town, or Location of Death <b>Olney</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>263-64-4702</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>90</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>April 2, 1906</b>		9. Birthplace (State or Foreign Country) <b>Massachusetts</b>
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10e. State <b>MD</b>	10b. County <b>Montgomery</b>	10c. City, Town or Location <b>Silver Spring</b>			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number <b>3700 International Drive</b>			10f. Zip Code <b>20906</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>2</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>				
	17. Father's Name (First, Middle, Last) <b>Walter Ellis Oliver</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Cora Alice Pope</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Elaine Clarkin (Daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3602 Pimlico Place, Silver Spring, MD 20906</b>				
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mount Comfort Crematory</b>		Date <b>8/13/96</b>	20c. Location - City or Town, State <b>Alexandria, Virginia</b>			
	21. Signature of Funeral Service Licensee <i>William Thomas R...</i>				22. Name and Address of Facility <b>Affordable Funeral Services</b> <b>7400 Lee Highway, Falls Church, VA 22042</b>				
	23a. Part I. Enter the disease, or complications that caused the death, not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
	Immediate Cause (Final disease or condition resulting in death) a. <b>Urocephsis</b> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>acute renal failure</b>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>D38457</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 11, 1996</b>			
30. Name and address of person who completed cause of death (from 23a) (Type, Print) <b>N. Goyaz MD, 1811 Prince Philip Dr, Olney MD 20832</b>									
31. Date filed (Month, Day, Year) <b>AUG 14 1996</b>		32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25613

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George C. Swink				2. Date of Death Month Day Year August 14, 1996		3. Time of Death 2:30 AM		
	4a. Facility Name (If not Institution, give street and number) 9008 Georgia Avenue				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 579-07-7211		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 20, 1915		
	9. Birthplace (State or Foreign Country) Virginia		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 9008 Georgia Avenue		10f. Zip Code 20910		10g. Citizen of What Country? United States	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner		16b. Kind of Business/Industry Electrical Contracting					
17. Father's Name (First, Middle, Last) George W. Swink				18. Mother's Name (First, Middle, Maiden Surname) Grace Virginia Follin					
19a. Informant's Name/Relationship (Type, Print) D. Lucille Swink				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veteran's Cemetery		20c. Date 8-15-96		20d. Location - City or Town, State Cheltenham, Maryland			
21. Signature of Funeral Service Licensee Eileen H. Rapp				22. Name and Address of Facility Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Metastatic Adenocarcinoma Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 2 months	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Atherosclerotic Cardiovascular Disease								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Raymond A. Bass MD		29c. License number D 21340		29d. Date signed (Month, Day, Year) August 14, 1996			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raymond A. Bass, M. D., 3941 Ferrara Drive, Wheaton, MD 20906-4709									
31. Date filed (Month, Day, Year) AUG 15 1996		32. Registrar's Signature Michael Gordon-Randall							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25614

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Alberta L. Summerville

2. Date of Death

Month Day Year  
August 10, 1996

3. Time of Death

10:00 PM

4e. Facility Name (If not institution, give street and number)

Springbrook Adventist Nursing Home

4b. City, Town, or Location of Death

Silver spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

578-03-1408

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

101

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 5, 1895

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10e. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12325 New Hampshire Avenue

10f. Zip Code

20904

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
416e. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Registered Nurse

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

Unavailable

18. Mother's Name (First, Middle, Maiden Surname)

Unavailable

19e. Informant's Name/Relationship (Type, Print)

Walter W. H. Verdier

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #1620

1131 University Blvd., West, Silver Spring, MD 20902

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Lincoln Memorial Cemetery 8-15-96 Suitland, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Eileen H. Rapp

22. Name and Address of Facility

Rapp Funeral Services, P. A.  
933 Gist Avenue, Silver Spring, MD 2091023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Subdural Hematoma

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☒ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28e. Date of Injury  
(Month, Day Year)

8-9-96

28b. Time of  
Injury

PM

28c. Injury at  
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Fall

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

Nursing Home

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)12325 New Hampshire Ave.  
Silver Spring, Maryland29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

John F. Tauber

29c. License number

D08965

29d. Date signed (Month, Day, Year)

August 14 - 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

John F. Tauber, M. D., 8218 Wisconsin Avenue, #318, Bethesda, MD 20814

31. Date filed (Month, Day, Year)

AUG 15 1996

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25615

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANTHONY EDWARD SZYMKOWIAK				2. Date of Death Month Day Year AUGUST 10, 1996		3. Time of Death 6:03 PM					
	4a. Facility Name (If not Institution, give street and number) HOLY CROSS HOSPITAL				4b. City, Town, or Location of Death SILVER SPRING		4c. County of Death MONTGOMERY					
Funeral Director	5. Social Security Number 209-30-6122		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 54 Yrs.		8. Date of Birth Month Day Year SEPT 20, 1941		9. Birthplace (State or Foreign Country) PENNSYLVANIA			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County MONTGOMERY		10c. City, Town or Location GAITHERSBURG				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number #1 RELDA COURT				10f. Zip Code 20878		10g. Citizen of What Country? UNITED STATES					
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TEACHER			16b. Kind of Business/Industry EDUCATION					
	17. Father's Name (First, Middle, Last) EDWARD SZYMKOWIAK				18. Mother's Name (First, Middle, Maiden Surname) MARY A. MANDAK							
	19a. Informant's Name/Relationship (Type, Print) MARY ANN SZYMKOWIAK, WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #1 RELDA COURT, GAITHERSBURG, MD 20878							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GATE OF HEAVEN CEMETERY		20c. Date 8/13/96		20d. Location - City or Town, State SILVER SPRING, MD					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility DeVOL FUNERAL HOME 10 EAST DEER PARK DR., GAITHERSBURG, MD 20877							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial infarction Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):										Approximate Interval Between Onset and Death 2 weeks	
	Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred			
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) as stated.		29b. Signature and title of certifier 				29c. License number D 21611		29d. Date signed (Month, Day, Year) 8/11/96			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Barr, MD, Holy Cross Hospital, 1500 Forest Glen, Silver Spring, MD											
State Registrar	31. Date filed (Month, Day, Year) AUG 14 1996		32. Registrar's Signature 									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25616

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RASHEEDE

2. Date of Death

Month

Day

Year

3. Time of Death

SMITH

JULY

20

1996

7:38 P.M.

4a. Facility Name (If not institution, give street and number)

ANNE ARUNDEL MEDICAL CENTER

4b. City, Town, or Location of Death

ANNAPOLIS

4c. County of Death

ANNE ARUNDEL

Funeral  
Director

5. Social Security Number

N/A

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

7

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

2/18/89

9. Birthplace (State or Foreign Country)

Wash. DC

Usual Residence of Decedent

10a. State

DC

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3731 9th St. N.W.

10f. Zip Code

20010

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
Black15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
2nd

College (1-4or 5+)

16e. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Richard Smith

18. Mother's Name (First, Middle, Maiden Surname)

Cynthia Aldridge

19a. Informant's Name/Relationship (Type, Print)

Richard Smith Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3731 9th St. NW Wash. DC 20010

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Harmony Memorial Prk 7/26/96 Landover, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Jerry A. Austin

22. Name and Address of Facility

Austin Royster Funeral Home  
3605 14th St. NW Wash. DC 2001023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e.

Due to (or as a consequence of):

Drowning

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28e. Date of Injury

(Month, Day, Year)  
7-20-96

28b. Time of Injury

UNK M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

subject drowned at beach

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)

STATE PARK

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

SANDY POINT, MARYLAND

29a. Certifier  
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. A. Locke MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JULY 21, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. A. Locke MD

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 13 1996

32. Registrar's Signature

J. A. Locke MD

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25617

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ABDUL SATTAH</b>				2. Date of Death Month Day Year <b>Aug. 8, 1996</b>		3. Time of Death <b>3:02A.</b>		
	4a. Facility Name (If not Institution, give street and number) <b>Washington Adventist Hospital</b>				4b. City, Town, or Location of Death <b>Takoma Park</b>		4c. County of Death <b>Montgomery</b>		
Funeral Director	5. Social Security Number <b>unknown</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>66</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov. 6, 1930</b>		
	9. Birthplace (State or Foreign Country) <b>India</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Olney</b>		
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>10 Gelding Court</b>		10f. Zip Code <b>20832</b>		10g. Citizen of What Country? <b>India</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Asian</b>		
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Technician</b>		16b. Kind of Business/Industry <b>Telco</b>		17. Father's Name (First, Middle, Last) <b>Rahman Shaikh</b>		
	18. Mother's Name (First, Middle, Maiden Surname) <b>unknown</b>		19a. Informant's Name/Relationship (Type, Print) <b>Rahmutinisa Sattar (wife)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>same as #10</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
Physician /Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>George Washington Cemetery</b>		20c. Date <b>8/8/1996</b>		20d. Location - City or Town, State <b>Adelphi, Maryland</b>		21. Signature of Funeral Service Licensee <b>Donald V. Borgwardt</b>		
	22. Name and Address of Facility <b>Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Md. 20705</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>CONGESTIVE CARDIAC FAILURE</b> Due to (or as a consequence of): <b>CONGESTIVE CARDIOMYOPATHY</b> Due to (or as a consequence of): <b>RENAL FAILURE</b>		Approximate Interval Between Onset and Death <b>2 WEEKS</b> <b>UNKNOWN.</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
State Registrar	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		
	29b. Signature and title of certifier <b>Rahman</b>		29c. License number <b>D22910</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 8TH 1996</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>ASIF S. QADRI, 4700 BERWYN HOUSE RD, COLLEGE PARK MD 20740</b>		
31. Date filed (Month, Day, Year) <b>AUG 12 1996</b>		32. Registrar's Signature <b>[Signature]</b>		33. Registrar's Title <b>[Signature]</b>		34. Registrar's Name <b>[Signature]</b>		35. Registrar's Address <b>[Signature]</b>	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25618

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) THOMAS OLIVER TYLER III				2. Date of Death Month August Day 12 Year 1996		3. Time of Death 6:10 pm	
	4a. Facility Name (If not Institution, give street and number) 3555 Elliott Island Rd.				4b. City, Town, or Location of Death Vienna		4c. County of Death Dorchester	
Funeral Director	5. Social Security Number 218-36-6999		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 55 Yrs.		8. Date of Birth (Month, Day, Year) May 27 1941	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Dorchester		10c. City, Town or Location Vienna	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 3555 Elliott Island Rd.		10f. Zip Code 21869		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1959-1963		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Forester		16b. Kind of Business/Industry manufacturing of wood & paper products			
	17. Father's Name (First, Middle, Last) Thomas Oliver Tyler Jr.				18. Mother's Name (First, Middle, Maiden Surname) Katherine Phillips			
To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print) Mrs. Virginia Tyler - wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3555 Elliott Island Rd., Vienna, MD 21869			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory		20c. Location - City or Town, State Salisbury, Md.			
To Be Completed by Funeral Director	21. Signature of Funeral Service Licensee Kenneth R. Thomas Jr.				22. Name and Address of Facility Thomas Funeral Home PA 700 Locust St. Cambridge, MD 21613			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Lung Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 9 months			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier J. E. [Signature]		29c. License number 030690		29d. Date signed (Month, Day, Year) Aug. 13, 1996	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James E. Martin, M.D., 145 E. Carroll St., Salisbury, MD.							
	31. Date filed (Month, Day, Year) AUG 16 1996		32. Registrar's Signature Julia [Signature]					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

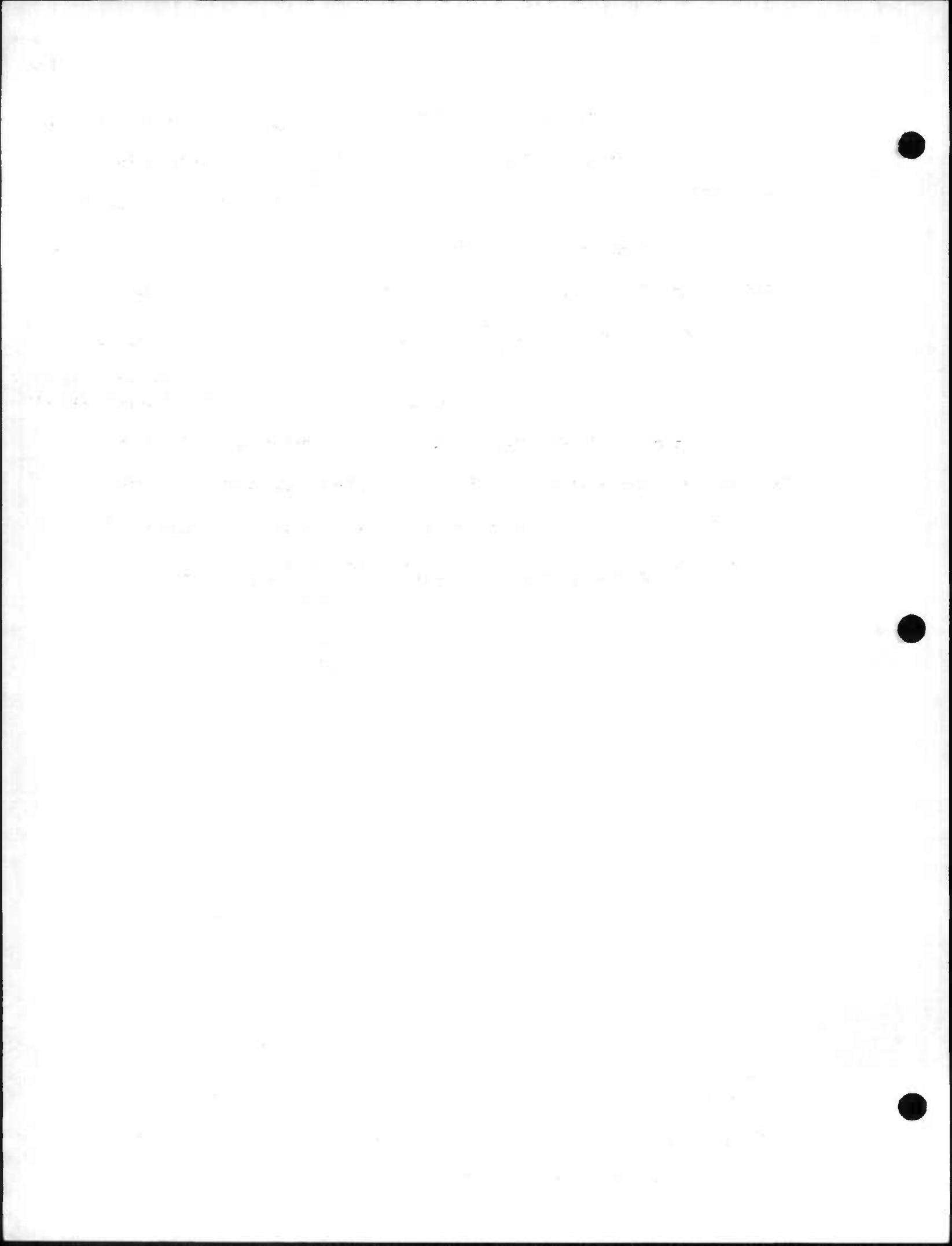
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

96 25619

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HAZEL MAE TURNER				2. Date of Death Month Day Year Aug 12 96		3. Time of Death 4:58PM
	4a. Facility Name (If not Institution, give street and number) Memorial Hospital at Easton				4b. City, Town, or Location of Death Easton		4c. County of Death Talbot
Funeral Director	5. Social Security Number 220-05-1551	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 5, 1914	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State Maryland		10b. County Talbot		10c. City, Town or Location Easton		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	10e. Street and Number 400 E. Dover Street, Apt. 203				10f. Zip Code 21601		10g. Citizen of What Country? USA
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4or 5+) _____		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic- Factory & Cleaning		16b. Kind of Business/Industry Canning Factory & Board of Education		
	17. Father's Name (First, Middle, Last) Joseph Johns, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Emma Ennals		
To Be Completed by Physician/Medical Examiner	19e. Informant's Name/Relationship (Type, Print) Karen Roberts				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3633 Barber Hgts. Road, Trappe, Md. 21673		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Paradise Cemetery		Date 8/17/96	20c. Location - City or Town, State Trappe, Md.	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Bennie Smith Funeral Home P.O. Box 1687, Easton, Maryland 21601		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>end stage liver disease</u> Due to (or as a consequence of): b. <u>cirrhosis</u> Due to (or as a consequence of): c. <u>autoimmune chronic active hepatitis</u> Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____						
State Registrar	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input checked="" type="checkbox"/> Other (Specify) <u>Emer. Rm</u>		
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred		
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				28b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier M.D.		
29c. License number D25750				29d. Date signed (Month, Day, Year) 8/13/96			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ROBERT B. SANCHEZ M.D. 508 Edgewild Ave Easton MD							
31. Date filed (Month, Day, Year) AUG 14 1996				32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



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State of Maryland / Department of Health and Mental Hygiene

96 25620

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy Fulton TRAIL

2. Date of Death

August 12, 1996

3. Time of Death

5:30 A.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Collingswood National Rehabilitation Hospital Rockville

4b. City, Town, or Location of Death

4c. County of Death

Montgomery

5. Social Security Number

218-48-2890

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 20, 1904

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15311 Beaverbrook Court, Apt. 93-D

10f. Zip Code

20906

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

School Teacher

16b. Kind of Business/Industry

High School

17. Father's Name (First, Middle, Last)

Edward

Gale

18. Mother's Name (First, Middle, Maiden Surname)

Amy

Kemp

19a. Informant's Name/Relationship (Type, Print)

William E. Trail, Jr., Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15311 Beaverbrook Court, Apt. 93-D, Silver Spring, MD 20906

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Smithsburg Crematory, Aug. 13, 1996 Smithsburg, Maryland

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Allan H Ruby M00703

22. Name and Address of Facility

Keeney & Basford P.A. Funeral Home  
106 East Church Street, Frederick, MD 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ARTERIOSCLEROTIC VASCULAR DISEASE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Acute

25 YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Thomas E. Dooley, M.D.

29c. License number

D16458

29d. Date signed (Month, Day, Year)

August 13, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Thomas E. Dooley, M.D., 17904 Georgia Avenue, Suite 304, Olney, MD 20832

31. Date filed (Month, Day, Year)

AUG 15 1996

32. Registrar's Signature

Lisa Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25621

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Alberta Thompson</b>				2. Date of Death Month <b>08</b> Day <b>06</b> Year <b>96</b>		3. Time of Death <b>3:40 A</b>	
	4a. Facility Name (If not institution, give street and number) <b>Allego Bethesda Rehabilitation + Nursing Center</b>				4b. City, Town, or Location of Death <b>Bethesda</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>577-145456</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>92</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>07-18-04</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent				10c. City, Town or Location <b>Washington</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10a. State <b>D. C.</b>		10b. County		10f. Zip Code <b>20011</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Baker</b>		16b. Kind of Business/Industry <b>Private Industry</b>		
17. Father's Name (First, Middle, Last) <b>Albert Thompson, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Alberta (unk)</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Bessie J. Williams (Friend)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1336 Ingraham St., N. W., Wash., DC 20011</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Maryland National</b>		20c. Location - City or Town, State <b>8-14-96 Laurel, Md.</b>		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>R.N. Horton Co, Mort. Fac. 600 Kennedy ST. N.W. Wash, D.C.</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>Sepsis</b> Due to (or as a consequence of): b. <b>Arteriovascular Accident</b> Due to (or as a consequence of): c. <b>Hypertension</b> Due to (or as a consequence of): d.  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Approximate Interval Between Onset and Death <b>days</b> <b>weeks</b> <b>years</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospice: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		
				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
				28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>Elliott R. Goldstein</b>				
				29c. License number <b>003581</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 13, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Elliott R. Goldstein 9410 Old Georgetown Rd., Bethesda, Md.</b>								
31. Date filed (Month, Day, Year) <b>AUG 15 1996</b>				32. Registrar's Signature <i>[Signature]</i>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25622

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROSEMARY BLAKE VANCE</b>				2. Date of Death Month Day Year <b>AUGUST 14, 1996</b>				3. Time of Death <b>5:15 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>35821 AVIATION YACHT CLUB ROAD</b>				4b. City, Town, or Location of Death <b>MECHANICSVILLE</b>				4c. County of Death <b>ST. MARY'S</b>	
Funeral Director	5. Social Security Number <b>235-54-9276</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>60</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>APRIL 17, 1936</b>		9. Birthplace (State or Foreign Country) <b>WEST VIRGINIA</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>		10b. County <b>ST. MARY'S</b>		10c. City, Town or Location <b>MECHANICSVILLE</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>9 SHOREVIEW DRIVE</b>				10f. Zip Code <b>20659</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>BRANCH CHIEF</b>				16b. Kind of Business/Industry <b>U.S. CENSUS BUREAU</b>			
	17. Father's Name (First, Middle, Last) <b>JESSE DONALD BLAKE</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MARGARET ANN PACK</b>					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>RANDALL R. VANCE / SON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>140 ANNE COURT, MECHANICSVILLE, MD 20659</b>					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MARYLAND VETERAN'S CEMETERY</b>		Data <b>AUG. 19, 1996</b>		20c. Location - City or Town, State <b>CHELTENHAM, MARYLAND</b>			
	21. Signature of Funeral Service Licensee <b>MARK G. BROWHAN MO0053</b>				22. Name and Address of Facility <b>THE HUNTT FUNERAL HOME P.O. BOX 156, WALDORF, MARYLAND 20604</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>carcinoma of colon</b>									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Dr. Bruce A. Silver, MD</b>		29c. License number <b>021463</b>		29d. Date signed (Month, Day, Year) <b>8-14-96</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>BRUCE A. SILVER, MD 2101 Medical Park Dr. Silver Spring, MD 20902</b>										
31. Date filed (Month, Day, Year) <b>AUG 16 1996</b>		32. Registrar's Signature <b>John Davidson-Randall</b>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that proper record-keeping is essential for the integrity of the financial system and for the ability to detect and prevent fraud.

2. The second part of the document outlines the specific procedures for recording transactions. It details the steps involved in the accounting process, from the initial entry of data into the system to the final review and approval of the records.

3. The third part of the document addresses the challenges associated with maintaining accurate records. It identifies common sources of error and provides strategies for minimizing these errors, such as implementing strict controls and regular audits.

4. The fourth part of the document discusses the role of technology in improving record-keeping. It highlights the benefits of using automated systems to process transactions and generate reports, and provides examples of how these systems can be implemented effectively.

5. The fifth part of the document concludes by emphasizing the ongoing nature of the record-keeping process. It stresses the need for continuous monitoring and improvement, and encourages the use of best practices to ensure the highest level of accuracy and reliability.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25623

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Daniel Ile Weedon				2. Date of Death Month Day Year August 14, 1996		3. Time of Death 9:45 PM	
	4a. Facility Name (If not institution, give street and number) 407 W. South St.				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 214-30-2036		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 17, 1920	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 407 W. South St.				10f. Zip Code 21701		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) -				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Technician		16b. Kind of Business/Industry Telephone co.		
17. Father's Name (First, Middle, Last) Ile Weedon				18. Mother's Name (First, Middle, Maiden Surname) Cecilia Frances Scott				
19a. Informant's Name/Relationship (Type, Print) Sarah Weedon				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 407 W. South St./ Frederick, Maryland 21701				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Hagerstown Crematory		Date 8-15-96		20c. Location - City or Town, State Hagerstown, Maryland	
21. Signature of Funeral Service Licensee <i>Raymond Putnam</i>				22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick, Md. 21702				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Prostate cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Kathleen W Stern MD		29c. License number D32073		29d. Date signed (Month, Day, Year) 8/15/96		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Kathleen W Stern 610 Ninth Ave Brunswick Md 21716								
31. Date filed (Month, Day, Year) AUG 16 1996		32. Registrar's Signature <i>J. A. [Signature]</i>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State  
Registrar



Amended #1, 8/14/96, MRT, Montgomery County

96 25624

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Leonard</b>		ANDREW		WEPASNICK <i>Wepasonick</i> SR.		2. DATE OF DEATH MONTH <b>August</b> DAY <b>13</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>0202</b> M							
4. SOCIAL SECURITY NUMBER <b>116-20-8853</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>67</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>		7. DATE OF BIRTH (Month, Day, Year) <b>Nov. 28, 1928</b>		8. BIRTHPLACE (State or Foreign Country) <b>New York</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>SHADY GROVE ADVENTIST HOSPITAL</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>Rockville</b>				9c. COUNTY OF DEATH <b>Montgomery</b>					
10a. STATE <b>Maryland</b>						10b. COUNTY <b>Montgomery</b>				10c. CITY, TOWN OR LOCATION <b>Kensington</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3509 Astoria Road</b>						10f. ZIP CODE <b>20895</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1951-1953</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Intelligence Officer</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Central Intelligence Agency</b>									
17. FATHER'S NAME (First, Middle, Last) <b>Maximillian Wepasnick</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Eva Curmanska</b>									
19a. INFORMANT'S NAME (Type/Print) <b>Corda H. Wepasnick</b>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3509 Astoria Road Kensington, Maryland 20895</b>									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Arlington National Cemetery</b> DATE <b>8/20/96</b>				20c. LOCATION — City or Town, State <b>Arlington, Virginia</b>									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Steven J. Stroud</i>						22. NAME AND ADDRESS OF FACILITY <b>Francis J. Collins Funeral Home, Inc.</b> <b>500 University Blvd., W. Sil. Spr., MD 20901</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): <b>Renal Failure</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):  Approximate Interval Between Onset and Death <b>3 days</b> <b>5 yrs</b>															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER <i>MD</i>						29c. LICENSE NUMBER <b>D21340</b>		29d. DATE SIGNED (Month, Day, Year) <b>August 13, 1996</b>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>RAYMOND BASS 3941 Ferrara Dr. Wheaton, Md 20906</b>															
31. DATE FILED (Month, Day, Year) <b>AUG 14 1996</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>											

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 25625

## Reg. No.

DMMH 16 Rev 6/95





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25626

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Wildurr Willing</b>				2. Date of Death Month <b>August</b> Day <b>10</b> Year <b>1996</b>		3. Time of Death <b>4:28 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>10450 Lottsford Road, #2206</b>				4b. City, Town, or Location of Death <b>Mitchellville</b>		4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>017-22-0902</b>	8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>87</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Oct. 22, 1908</b>		9. Birthplace (State or Foreign Country) <b>Mississippi</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Mitchellville</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>10450 Lottsford Road, #2206</b>				10f. Zip Code <b>20721</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Office Manager</b>		16b. Kind of Business/Industry <b>Car Rental</b>		
17. Father's Name (First, Middle, Last) <b>Wildurr Willing</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Jessie McNair</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Robert Patton Willing</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10450 Lottsford Road, #142, Mitchellville, MD 20721</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory</b>		20c. Date <b>8-12-96</b>		20d. Location - City or Town, State <b>Beltsville, Maryland</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Acute Myocardial Infarction</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>1 day</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Old Cerebrovascular Accident</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number <b>D25079</b>		29d. Date signed (Month, Day, Year) <b>August 11, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Don Yablonsky, M. D., 7404 Executive Place, #502, Seabrook, MD 20706</b>								
31. Date filed (Month, Day, Year) <b>AUG 12 1996</b>		32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25627

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Veronica L. Wood						2. Date of Death Month Day Year August 8, 1996		3. Time of Death 2:48 P.M.													
	4a. Facility Name (If not Institution, give street and number) FREDERICK MEMORIAL HOSPITAL						4b. City, Town, or Location of Death FREDERICK		4c. County of Death FREDERICK													
Funeral Director	5. Social Security Number 214-62-8405		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 45 Yrs.		8. Date of Birth (Month, Day, Year) AUG. 4, 1951		9. Birthplace (State or Foreign Country) MARYLAND													
	Usual Residence of Decedent																					
To Be Completed by Funeral Director	10e. State MARYLAND		10b. County FREDERICK		10c. City, Town or Location FREDERICK				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No													
	10e. Street and Number 6105 BALDRIDGE TERRACE				10f. Zip Code 21701		10g. Citizen of What Country? UNITED STATES															
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE														
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collega (1-4or 5+) 4				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NURSE			16b. Kind of Business/Industry HOSPITAL														
	17. Father's Name (First, Middle, Last) (UNKNOWN) SIDOR						18. Mother's Name (First, Middle, Maiden Surname) CONSTANCE (UNKNOWN)															
	19a. Informant's Name/Relationship (Type, Print) ELIZABETH KAREN SHOEMAKER/FRIEND						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6105 BALDRIDGE TERRACE, FREDERICK, MD. 21701															
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) SALEM CEMETERY			Date 8/12/96		20c. Location - City or Town, State BROOKEVILLE, MD.													
	21. Signature of Funeral Service Licensee Muriel H. Barber						22. Name and Address of Facility MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882															
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																					
	<table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td>Ventricular Fibrillation</td> <td>12 hr</td> </tr> <tr> <td>b.</td> <td>CORONARY ARTERY DISEASE</td> <td>10 mo</td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Ventricular Fibrillation	12 hr	b.	CORONARY ARTERY DISEASE	10 mo	c.			d.	
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Ventricular Fibrillation	12 hr																			
	b.	CORONARY ARTERY DISEASE	10 mo																			
	c.																					
	d.																					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES mellitus Renal Failure																						
23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																						
24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																						
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																						
28. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined																						
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)																						
28b. Location (Street and Number or Rural Route Number, City or Town, State)																						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																						
29b. Signature and title of certifier MARK P. RUBIN, M.D.																						
29c. License number 29591																						
29d. Date signed (Month, Day, Year) 8/8/96																						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARK P. RUBIN 201 Thomas Johnson Drive Frederick MD 21702																						
31. Date filed (Month, Day, Year) AUG 12 1996																						
32. Registrar's Signature Kardon-Rodriguez																						

Baltimore, Maryland 21215-0020

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar



96 25628

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>RUTH WIIKKA</b>				2. DATE OF DEATH MONTH DAY YEAR <b>August 13, 1996</b>		3. TIME OF DEATH <b>12:28 PM</b>	
4. SOCIAL SECURITY NUMBER <b>016-12-9746</b>		5. SEX <b>1 M 2 F</b>		6. AGE (In yrs. last birthday) <b>76</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug. 1, 1920</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Washington Adventist Nursing &amp; Rehabilitation Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Takoma Park</b>		9c. COUNTY OF DEATH <b>Montgomery</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Takoma Park</b>		10d. INSIDE CITY LIMITS? <b>1 YES 2 NO</b>	
10e. STREET AND NUMBER <b>7207 Central Avenue</b>				10f. ZIP CODE <b>20912</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <b>1 Never Married 2 Married</b> <b>3 Widowed 4 Divorced</b>		12. WAS DECEDENT EVER IN U.S. ARMY FORCES? <b>1 YES 2 NO</b> IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 NO</b> Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (8-12)</b>		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Budget Analyst</b>		17. KIND OF BUSINESS/INDUSTRY <b>Federal Government</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Julius F. Wiinikka</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Marian Tallila</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Alma M. Johnson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7207 Central Avenue Takoma Park, Maryland 20912</b>			
20a. METHOD OF DISPOSITION <b>1 Burial 2 Cremation 3 Removal from State</b> <b>4 Donation 5 Other (Specify)</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metropolitan Crematory 8/14/96 Alexandria, Virginia</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Timothy G. Campbell</b>				22. NAME AND ADDRESS OF FACILITY <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>a. Respiratory Failure</b> <b>b. Aspiration Pneumonia</b> <b>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b> <b>c.</b> <b>d.</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>cerebrovascular Accident</b>							
24a. WAS AN AUTOPSY PERFORMED? <b>1 YES 2 NO</b>		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 YES 2 NO</b>					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 YES 2 NO</b>		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>					
27. MANNER OF DEATH <b>1 Natural 2 Accident 3 Suicide 4 Homicide</b> <b>5 Pending Investigation 6 Could not be determined</b>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1 YES 2 NO</b>	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>M Karimi MD</b>				29c. LICENSE NUMBER <b>D-18895</b>		29d. DATE SIGNED (Month, Day, Year) <b>August 13, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MOBARAK KARIM, 7610 CARROLL AVENUE, TAKOMA PARK, MD 20912</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 14 1996</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25629

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William A. Walter, Jr.				2. Date of Death Month Day Year August 11, 1996		3. Time of Death 4:55 am	
	4e. Facility Name (If not institution, give street and number) 6310 Wilson Lane				4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 310-14-2604	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 17, 1922		9. Birthplace (State or Foreign Country) Pennsylvania
	Usual Residence of Decedent							
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Bethesda		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 6310 Wilson Lane				10f. Zip Code 20817		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical Doctor		16b. Kind of Business/Industry Medicine		
17. Father's Name (First, Middle, Last) William A. Walter, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Theresa Shank				
19a. Informant's Name/Relationship (Type, Print) Carol P. Walter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6310 Wilson Lane, Bethesda, MD 20817				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) Entombment		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		Date 8/14/96		20c. Location - City or Town, State Silver Spring, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)		a. Respiratory Failure Due to (or as a consequence of):					6 Min.	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Metastasis to Bone Due to (or as a consequence of):					10 Months	
		c. Non - small Cell Lung Cancer Due to (or as a consequence of):					1-2 Years	
		d.						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Collapsed right lower lobe Secondary to tumor compression						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number D23540		29d. Date signed (Month/Day, Year) 8/13/96		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Hugh Hill, M.D., 1450 Research Blvd., Rockville, MD 20850								
31. Date filed (Month, Day, Year) AUG 14 1996				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25630

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Anna G. Williams

2. Date of Death

Month Day Year  
August 12, 1996

3. Time of Death

6:00 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Allegis Kensington Nursing Home

4b. City, Town, or Location of Death

Kensington

4c. County of Death

Montgomery

5. Social Security Number

217-28-8121

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

98 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 18, 1898

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1611 Dublin Drive

10f. Zip Code

20902

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Assistant to the Courier

16b. Kind of Business/Industry

American Red Cross

17. Father's Name (First, Middle, Last)

William E. Olinger

18. Mother's Name (First, Middle, Maiden Surname)

Annie E. Braund

19a. Informant's Name/Relationship (Type, Print)

Frederick G. Williams

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1695 Epping Farm Lane Annapolis, Maryland 21401

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Arlington National Cemetery

Date

8/16/96

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

Andrew J. Cole

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W. Sil. Spr., Maryland 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Uremia

Due to (or as a consequence of):

b. Urinary Tract Infection

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

Urinary Incontinence

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOAOther: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending

Investigation

☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

M

28c. Injury at

Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Edward J. Richards, M.D.

29c. License number

D-12703

29d. Date signed (Month, Day, Year)

8-13-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Edward J. Richards, M.D. 10301 Georgia Avenue #104 Silver Spring, Maryland 20902

31. Date filed (Month, Day, Year)

AUG 14 1996

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

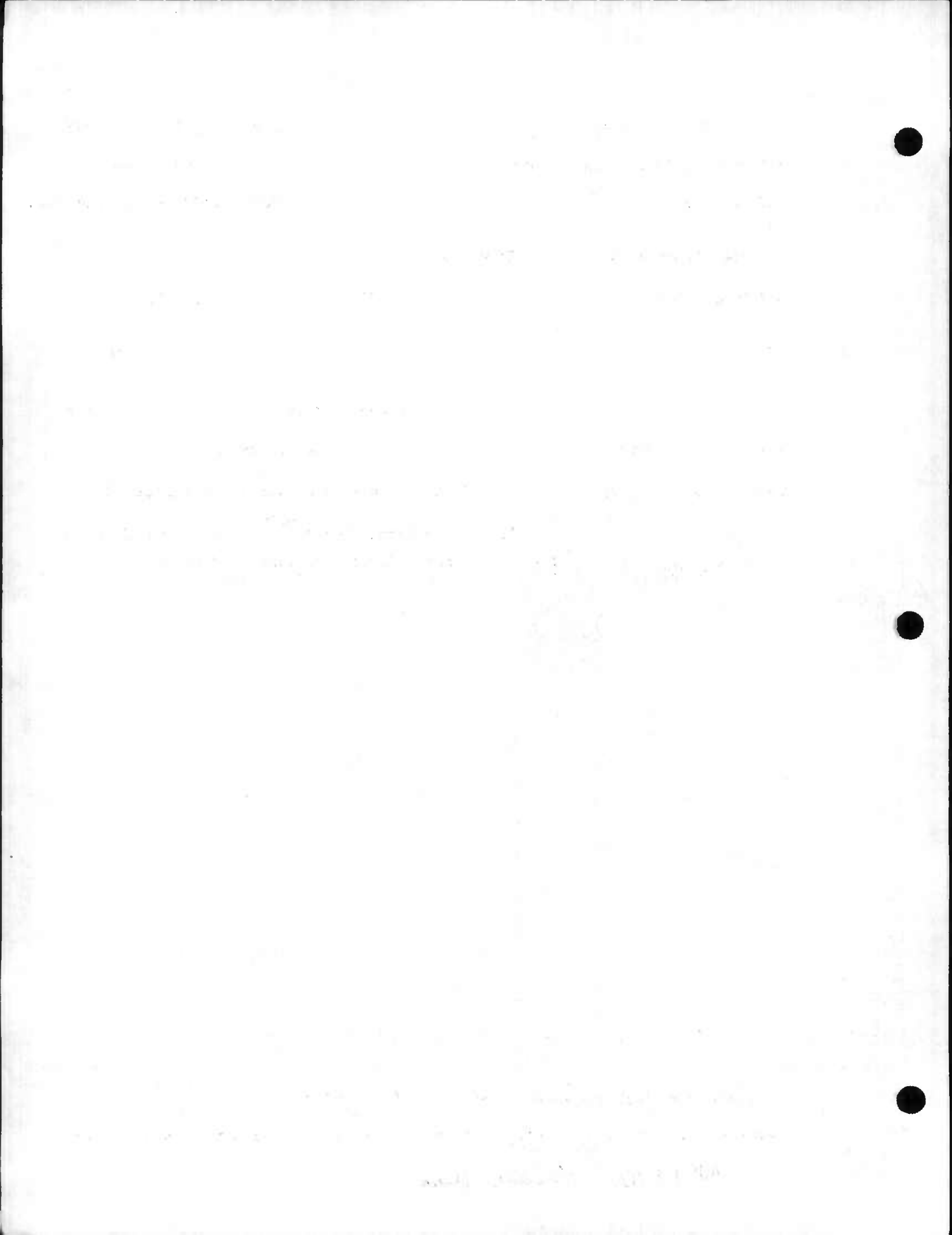
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25631

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>James L. Walsh</b>		2. Date of Death Month <b>8</b> Day <b>15</b> Year <b>96</b>		3. Time of Death <b>4:30 PM</b>
	4e. Facility Name (If not institution, give street and number) <b>Carroll County General Hospital</b>		4b. City, Town, or Location of Death <b>Westminster</b>		4c. County of Death <b>Carroll</b>
Funeral Director	5. Social Security Number <b>220-28-9026</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>65</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>April 3, 1931</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10c. City, Town or Location <b>Finksburg</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. State <b>MD</b>	10b. County <b>Carroll</b>			
	10e. Street and Number <b>1112 Ridge Road</b>		10f. Zip Code <b>21048</b>		10g. Citizen of What Country? <b>United States</b>
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>Korean</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>laborer</b>		16b. Kind of Business/Industry <b>Congoleum Corp.</b>
	17. Father's Name (First, Middle, Last) <b>James N. Walsh</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Fannie Myrle Abbott</b>		
	19e. Informant's Name/Relationship (Type, Print) <b>Gene A. Walsh, brother</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1112 Ridge Road, Finksburg, MD 21048</b>		
	20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Evergreen Memorial Gardens</b>		20c. Location - City or Town, State <b>Finksburg, MD</b>
	21. Signature of Funeral Service Licensee <b>Katherine Pritts - Switzer</b>		22. Name and Address of Facility <b>Pritts Funeral Home &amp; Chapel 412 Washington Rd., Westminster, MD 21157</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Respiratory Arrest</b> Due to (or as a consequence of): <b>b. Sepsis</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>				Approximate Interval Between Onset and Death <b>10 min</b> <b>12 hrs</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hepatic Failure, Congestive Heart Failure</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how Injury occurred		
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Medical Certification: To Be Completed by Physician/Medical Examiner	29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier <b>Robert M. Ricketts</b>		29c. License number <b>D39296</b>		29d. Date signed (Month, Day, Year) <b>8/15/96</b>
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Robert M. Ricketts CCGH Westminster, MD 21157</b>				
State Registrar	31. Date filed (Month, Day, Year) <b>AUG 16 1996</b>		32. Registrar's Signature <b>John Davidson-Randall</b>		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25632

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>William Roy Yagel</b>				2. Date of Death Month <b>August</b> Day <b>9</b> Year <b>1996</b>				3. Time of Death <b>6:00pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>829 Malibu Drive</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>				4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>578-34-7301</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>67</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan. 2, 1929</b>		9. Birthplace (State or Foreign Country) <b>Washington DC</b>	
	Usual Residence of Decedent				10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <b>829 Malibu Drive</b>				10f. Zip Code <b>20901</b>	
	10g. Citizen of What Country? <b>USA</b>				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Self Employed</b>				16b. Kind of Business/Industry <b>Aluminum Store</b>				17. Father's Name (First, Middle, Last) <b>Oliver Roy Yagel</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>Violet Swope</b>				19a. Informant's Name/Relationship (Type, Print) <b>Wanda Yagel</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>829 Malibu Drive, Silver Spring, MD 20901</b>	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>George Washington Cemetery 8/13/96 Adelphi, Maryland</b>				20c. Location - City or Town, State	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901</b>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Acute Alcohol Excess</b> Due to (or as a consequence of):  <b>b. </b> Due to (or as a consequence of):  <b>c. </b> Due to (or as a consequence of):  <b>d. </b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		
29b. Signature and title of certifier 				29c. License number <b>D08089</b>				29d. Date signed (Month, Day, Year) <b>August 12, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Michael Liebowitz, M.D., 11120 New Hampshire Ave. #305, Silver Spring, MD 20904</b>				31. Date filed (Month, Day, Year) <b>AUG 13 1996</b>				32. Registrar's Signature 		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25633

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William Wesley Bright

2. Date of Death

Month July Day 06 Year 1996

3. Time of Death

0321

4a. Facility Name (If not Institution, give street and number)

The Kent &amp; Queen Anne's Hospital Inc.

4b. City, Town, or Location of Death

Chestertown MD

4c. County of Death

Kent

Funeral  
Director

5. Social Security Number

220-01-8559

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month May Day 11 Year 1915

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

KENT

10c. City, Town or Location

WORTON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

26678 Bigwood's Road

10f. Zip Code

21678

10g. Citizen of What Country?

U. S. A

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

0-12

College (1-4or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LABOR

16b. Kind of Business/Industry

CONSTRUCTION

17. Father's Name (First, Middle, Last)

AARON BRIGHT

18. Mother's Name (First, Middle, Maiden Summa)

RACHEL JONES

19a. Informant's Name/Relationship (Type, Print)

MR. CHARLES WALLACE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Bigwood Rd. WORTON, MD. 21678

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

N.C. CATHOLIC CEM.

Date

7/11/96

20c. Location - City or Town, State

WORTON, MD. 21620

21. Signature of Funeral Service Licensee

Charles Wallace

22. Name and Address of Facility

WALTER FUNERAL HOME  
CHESTERTOWN, MD. 21620

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. COPD

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

{

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Arteriosclerotic Cardiovascular Disease -

Various CVA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

C. G. Bauman

29c. License number

200384

29d. Date signed (Month, Day, Year)

7/13/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C. G. BAUMAN 100 Brown St. Chestertown, Md 21620

31. Date filed (Month, Day Year)

JUL 15 '96

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified immediately.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25634

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>George Edward Brume</b>				2. Date of Death Month <b>June</b> Day <b>17</b> Year <b>1996</b>		3. Time of Death <b>15:10</b>	
	4a. Facility Name (If not Institution, give street and number) <b>Kent &amp; Queen Annes Hospital</b>				4b. City, Town, or Location of Death <b>Chestertown</b>		4c. County of Death <b>Kent</b>	
Funeral Director	5. Social Security Number <b>004-18-3175</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>78</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>March 17, 1918</b>	9. Birthplace (State or Foreign Country) <b>Maine (Portland)</b>
	Usual Residence of Decedent				10c. City, Town or Location <b>Chestertown</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Kent</b>		10e. Street and Number <b>100 Birch Run Road</b>		10f. Zip Code <b>21620</b>	
	10g. Citizen of What Country? <b>U.S.A.</b>		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Owner/Operator of Restaurant &amp; Marina</b>		16b. Kind of Business/Industry <b>Restaurant/Marina</b>		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	17. Father's Name (First, Middle, Last) <b>Percy Brume</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Veronica Guthro</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Mary Brume/Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>100 Birch Run Road, Chestertown, Maryland 21620</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Edgewood Memorial Park/June 20, 1996</b>		20c. Location - City or Town, State <b>Glen Mills, Pennsylvania</b>		21. Signature of Funeral Service Licensee <i>[Signature]</i>	
	22. Name and Address of Facility <b>Fellows, Helfenbein &amp; Newman Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. METASTATIC MALIGNANT MELANOMA</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. _____</b> Due to (or as a consequence of):  <b>c. _____</b> Due to (or as a consequence of):  <b>d. _____</b>		Approximate Interval Between Onset and Death			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26. Place of Death (Check only one)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>June 17, 1996</b>		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		
29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>D-13824</b>		29d. Date signed (Month, Day, Year) <b>6-17-96</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. John C. Seymour, 122 Speer Road, Chestertown, Maryland 21620</b>		
31. Date filed (Month, Day, Year) <b>JUN 19 '96</b>		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



96 25635

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Preston Oliver Cahall Sr.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>June 6, 1996</b>		3. TIME OF DEATH <b>1330</b>	
4. SOCIAL SECURITY NUMBER <b>215-12-7214</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>March 21, 1919</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>4 D Earleton Village (At Home)</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Cecilton</b>		9c. COUNTY OF DEATH <b>Cecil</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Cecil</b>		10c. CITY, TOWN OR LOCATION <b>Cecilton</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>4 D Earleton Village</b>				10f. ZIP CODE <b>21913</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES <b>W.W. II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Farmer</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Crop Farming</b>			
17. FATHER'S NAME (First, Middle, Last) <b>William Cahall</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>eva Wyatt</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Bessie R. Cahall</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4 D Earleton Village, Post Office Box 28, Cecilton, Maryland 21913</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Zion Cemetery - June 10, 1996</b>		20c. LOCATION — City or Town, State <b>Cecilton, Maryland</b>		22. NAME AND ADDRESS OF FACILITY <b>Fellows, Helfenbein &amp; Newman Funeral Home, P.A. 226 East Main Street, Cecilton, Maryland 21913</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>William L. King Jr.</b>				22. NAME AND ADDRESS OF FACILITY <b>Fellows, Helfenbein &amp; Newman Funeral Home, P.A. 226 East Main Street, Cecilton, Maryland 21913</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Gastrointestinal Cancer</b>					Approximate Interval Between Onset and Death <b>1 mos</b>
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. <b>DM II</b>					<b>10 yrs</b>
		c. <b>CVD</b>					<b>10 yrs</b>
		d. <b>HTN</b>					<b>20 yrs</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>June 6, 1996</b>		28b. TIME OF INJURY <b>1330</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dr. W. L. King Jr.</b>				29c. LICENSE NUMBER <b>044716</b>		29d. DATE SIGNED (Month, Day, Year) <b>6/10/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Will W. Highst Elkto MD 21921</b>							
31. DATE FILED (Month, Day, Year) <b>JUN 12 '96</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25636

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ruth Love Edwards				2. Date of Death Month Day Year June 26, 1996				3. Time of Death 12:15 p.m.	
	4a. Facility Name (If not institution, give street and number) Magnolia Hall Nursing Home				4b. City, Town, or Location of Death Chestertown				4c. County of Death Kent	
Funeral Director	5. Social Security Number 218-14-0892		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 89 Yrs.		8. Date of Birth (Month, Day, Year) March 1, 1907		9. Birthplace (State or Foreign Country) Clarksburg, WA	
	Usual Residence of Decedent				10a. State Maryland				10b. County Kent	
To Be Completed by Funeral Director	10c. City, Town or Location Rock Hall				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 21394 Bayside Drive	
	10f. Zip Code 21661				10g. Citizen of What Country? U.S.A.				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	
To Be Completed by Physician/Medical Examiner	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hairdresser				16b. Kind of Business/Industry Cosmetology	
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Arnett Love				18. Mother's Name (First, Middle, Maiden Surname) Cora Ward				19a. Informant's Name/Relationship (Type, Print) Bettie R. Ory/Daughter	
	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21394 Brittany Bay Drive, Rock Hall, Maryland 21661				20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Date Anatomy Board of Maryland June 26, 1996	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic Cardiovascular Disease 10 years Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ascites & esophageal varices, most likely 2° to cryptogenic cirrhosis Diabetes mellitus				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M				28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
	29b. Signature and title of certifier 				29c. License number MD. D17036				29d. Date signed (Month, Day, Year) 6/26/96	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Susan K. Ross, 516 Washington Avenue, Chestertown, Maryland 21620				31. Date filed (Month, Day, Year) JUN 26 '96				32. Registrar's Signature 	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25637

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joseph Michael Gorman				2. Date of Death Month Day Year June 12, 1996		3. Time of Death 11:15 a.m.	
	4e. Facility Name (If not institution, give street and number) Corsica Hills Center Genesis Elder Care				4b. City, Town, or Location of Death Centreville		4c. County of Death Queen Annes	
Funeral Director	5. Social Security Number 160-01-4688		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) October 13, 1907	
	10a. State Maryland		10b. County Kent		10c. City, Town or Location Rock Hall		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 5624 Circle Park Drive				10f. Zip Code 21661		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Insurance Auditor		16b. Kind of Business/Industry Insurance			
	17. Father's Name (First, Middle, Last) Thomas Gorman				18. Mother's Name (First, Middle, Maiden Surname) Julia Ryan			
	19e. Informant's Name/Relationship (Type, Print) Ann Marie Gorman-Mako/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 901 Jefferson Davis Highway, Fredricksburg, VA 22401			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Peter & Paul Cemetery/June		20c. Location - City or Town, State Springfield, Pennsylvania			
	21. Signature of Funeral Service Licensee <i>Gay B. Fellows</i>				22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620			
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <i>Cardiopulmonary Arrest</i> Due to (or as a consequence of): b. <i>Syncope</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension, Cerebrovascular Accident, Aortic, CHF</i>							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 8 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <i>none</i>		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <i>Ames</i>				29c. License number 823889		29d. Date signed (Month, Day, Year) June 12, 1996		
30. Name and address of person who completed cause of death (item 23a) (Type, Print) Dr. John C. Arrabal, 948 Washington Avenue, Chestertown, Maryland 21620								
31. Date filed (Month, Day, Year) JUN 13 '96		32. Registrar's Signature <i>Julia Davidson-Randall</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25638

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) Vera Laubert Harris				2. Date of Death Month: July 11, 1996 Day: 11, Year: 1996				3. Time of Death 2:22 a.m.		
	4a. Facility Name (If not institution, give street and number) Kent & Queen Annes Hospital				4b. City, Town, or Location of Death Chestertown				4c. County of Death Kent		
Funeral Director	5. Social Security Number 146-12-7221		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) March 3, 1924		9. Birthplace (State or Foreign Country) New Jersey		
	Usual Residence of Decedent										
10a. State Maryland		10b. County Queen Annes		10c. City, Town or Location Chestertown				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 1338 McGinnis Road, Cottontail Farm				10f. Zip Code 21620		10g. Citizen of What Country? U.S.A.					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Domestic/Own Home			
17. Father's Name (First, Middle, Last) Anthony Laubert				18. Mother's Name (First, Middle, Maiden Surname) Emily Butterhoff							
19a. Informant's Name/Relationship (Type, Print) John J. Harris/Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1338 McGinnis Road, Chestertown, Maryland 21620							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Crumpton Cemetery/July 15, 1996		20c. Location - City or Town, State Crumpton, Maryland					
21. Signature of Funeral Service Licensee <i>Shirley B. Fellows</i>				22. Name and Address of Facility Fellows, Helfenbein & Newman Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <i>Acute Myocardial infarction</i> Due to (or as a consequence of): b. <i>ASCVD</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 1 hr	
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> JOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
				28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>Harry P. Ross</i>				29c. License number D100001			
				29d. Date signed (Month, Day, Year) July 11, 1996							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Harry P. Ross, 516 Washington Avenue, Chestertown, Maryland 21620											
31. Date filed (Month, Day, Year) Jul 12 '96				32. Registrar's Signature <i>Julia Anderson-Randall</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 5056.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25639

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Russell Jones				2. Date of Death Month Day Year June 21, 1996		3. Time of Death 1206 pm	
	4a. Facility Name (If not institution, give street and number) Kent and Queen Anne's Hospital, Inc.				4b. City, Town, or Location of Death Chestertown		4c. County of Death Kent	
Funeral Director	5. Social Security Number 089-09-3413		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 94 Yrs.		8. Date of Birth (Month, Day, Year) 10-16-1902	
	9. Birthplace (State or Foreign Country) S. Carolina		10a. State MD		10b. County Kent		10c. City, Town or Location Rock Hall	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 5795 Chesapeake Villa		10f. Zip Code 21661		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1st		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer		16b. Kind of Business/Industry Moving and Storage				
17. Father's Name (First, Middle, Last) Crawford Jones				18. Mother's Name (First, Middle, Maiden Surname) Frances Lindsey				
19a. Informant's Name/Relationship (Type, Print) Cassie Jones - Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 600 Cannon St., Apt. 8, Chestertown, MD 21620				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Sharptown Cemetery		Date 6/24/96		20c. Location - City or Town, State Rock Hall, MD		
21. Signature of Funeral Service Licensee <i>James A. Perkins</i>				22. Name and Address of Facility James A. Perkins Funeral Service, P.O. Box 143, Rock Hall, MD 21661				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <i>pulmonary embolus</i> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>end stage congestive heart failure</i> <i>end stage chronic obstructive pulmonary disease</i>								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>m. Brownfield MD</i>				29c. License number A33514		29d. Date signed (Month, Day, Year) 6-24-96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 Brown St. Chestertown Md 21620								
31. Date filed (Month, Day, Year) JUN 24 '96		32. Registrar's Signature <i>J. Davidson-Randall</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

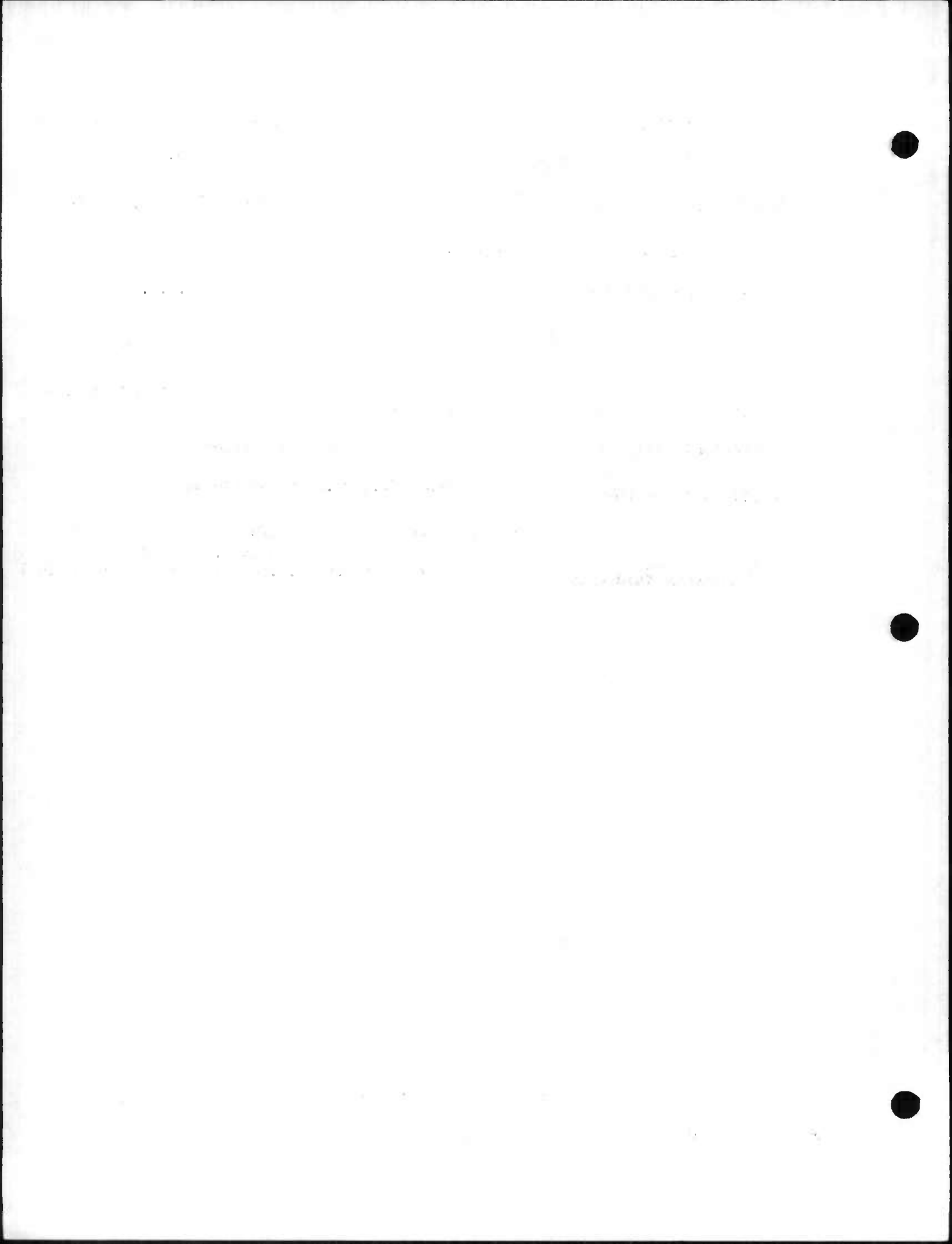
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25640

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Naomi Burris Lofland						2. Date of Death Month Day Year July 2, 1996		3. Time of Death 12:10 a.m.									
	4a. Facility Name (If not institution, give street and number) Heron Point						4b. City, Town, or Location of Death Chestertown		4c. County of Death Kent									
Funeral Director	5. Social Security Number 222-36-3166		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) May 13, 1910		9. Birthplace (State or Foreign Country) Delaware									
	Usual Residence of Decedent																	
To Be Completed by Funeral Director	10a. State Maryland		10b. County Kent		10c. City, Town or Location Chestertown				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No									
	10e. Street and Number 130 Heron Point				10f. Zip Code 21620		10g. Citizen of What Country? U.S.A.											
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White										
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) School Teacher			16b. Kind of Business/Industry Education											
	17. Father's Name (First, Middle, Last) Malcolm Burris						18. Mother's Name (First, Middle, Maiden Surname) Bertha Bedwell											
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) JoAnn Orange						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4005 Ayden Court, Mitchellville, Maryland 20721											
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Odd Fellows Cemetery		20c. Location - City or Town, State Smyrna, Delaware											
	21. Signature of Funeral Service Licensee <i>Jay B. Sallows</i>						22. Name and Address of Facility Fellows, Helfenbein & Newman Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620											
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																	
	<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequence list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td>a. BREAST CANCER WITH PULMONARY METASTASES</td> <td>2 yrs.</td> </tr> <tr> <td>b. ORIGINAL BREAST CANCER</td> <td>20 yrs.</td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)  Sequence list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. BREAST CANCER WITH PULMONARY METASTASES	2 yrs.	b. ORIGINAL BREAST CANCER	20 yrs.	c.		d.
Immediate Cause (Final disease or condition resulting in death)  Sequence list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. BREAST CANCER WITH PULMONARY METASTASES	2 yrs.																
	b. ORIGINAL BREAST CANCER	20 yrs.																
	c.																	
	d.																	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred										
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner		Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																
29b. Signature and title of certifier <i>Dr. A. Noble MD</i>		29c. License number D41587		29d. Date signed (Month, Day, Year) July 3, 1996														
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Helen Noble, 122 Speer Road, Chestertown, Maryland 21620																		
31. Date filed (Month, Day, Year) JUL 3 '96		32. Registrar's Signature <i>Julia Davidson-Randall</i>																

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Anne Marie Larson				2. DATE OF DEATH June 10 DAY 1996 YEAR				3. TIME OF DEATH 19:20 M	
4. SOCIAL SECURITY NUMBER 194-22-9848		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 20, 1927		8. BIRTHPLACE (State or Foreign Country) Morton, Pa.	
9a. FACILITY NAME (If not institution, give street and number) Union Hospital of Cecil County				9b. CITY, TOWN OR LOCATION OF DEATH Elkton				9c. COUNTY OF DEATH Cecil	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION Earleville				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 21 Summit Road				10f. ZIP CODE 21919		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs. College (1-4 or 5+) _____				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker			16b. KIND OF BUSINESS/INDUSTRY Home		
17. FATHER'S NAME (First, Middle, Last) Joseph A. Kelly				18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Murtha					
19a. INFORMANT'S NAME (Type/Print) George C. Larson, Sr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 Summit Rd. Earleville, Md. 21919					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Chesapeake Cremation Center 6-10			20c. LOCATION — City or Town, State Chester, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gay B. Fellows</i>				22. NAME AND ADDRESS OF FACILITY Fellows, Helfenbein & Newnam Funeral Home, P.A. 226 East Main St. Cecilton, Md. 21913					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Acute Myocardial Infarction</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>ATHEROSCLEROTIC CORONARY DISEASE WITH MYOCARDIAL INFARCTION 1974</i> c. <i>ASVD 2 MI 1974 &amp; Ventricular Tachycardia</i> DUE TO (OR AS A CONSEQUENCE OF): d. <i>Hypertension</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST									Approximate Interval Between Onset and Death hours years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Cerebral Vascular Disease</i> <i>Cerebrovascular Disease</i>									24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO									28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Barbara A. Parey MD</i>				29c. LICENSE NUMBER <i>025915</i>		29d. DATE SIGNED (Month, Day, Year) <i>6-11-96</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Barbara A. Parey Chesapeake Family Practice, Cecilton, Md. 21913									
31. DATE FILED (Month, Day, Year) JUN 12 '96				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25642

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Michael Emil Lepter				2. Date of Death Month Day Year July 9, 1996			3. Time of Death 20:14		
	4a. Facility Name (If not institution, give street and number) Kent & Queen Annes Hospital				4b. City, Town, or Location of Death Chestertown			4c. County of Death Kent		
Funeral Director	5. Social Security Number 041-26-2239		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 67 Yrs.		8. Date of Birth (Month, Day, Year) October 5, 1928		9. Birthplace (State or Foreign Country) Czechoslovakia	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Kent		10c. City, Town or Location Kennedyville				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 28874 Morgnec Road				10f. Zip Code 21645		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) 8				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dairy Farmer			16b. Kind of Business/Industry Agricultural		
	17. Father's Name (First, Middle, Last) John Lepter				18. Mother's Name (First, Middle, Maiden Surname) Juditha Thurner					
	19a. Informant's Name/Relationship (Type, Print) Anna K. Lepter/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28874 Morgnec Road, Kennedyville, Maryland 21645					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) St. Pauls Cemetery/July 13, 1996		Date July 13, 1996		20c. Location - City or Town, State Chestertown, Maryland	
	21. Signature of Funeral Service Licensee <i>Wayne Benjamin</i>				22. Name and Address of Facility Fellows, Helfenbein & Newman Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. Cerebral embolism @ 2 hemispheres 2 weeks Due to (or as a consequence of): b. Mitral stenosis & Atrial fibr. Due to (or as a consequence of): c. Rheumatic heart disease Due to (or as a consequence of): d.									
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide										
28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>Wayne Benjamin</i>				29c. License number 016498			29d. Date signed (Month, Day, Year) 7/10/96			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Wayne Benjamin, Brown Street, Chestertown, Maryland 21620										
31. Date filed (Month, Day, Year) JUL 11 '96				32. Registrar's Signature <i>Gina Davidson-Randall</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25643

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ida Rebecca Nitsch				2. Date of Death Month Day Year June 25, 1996		3. Time of Death 14:15		
	4a. Facility Name (If not institution, give street and number) Kent & Queen Annes Hospital				4b. City, Town, or Location of Death Chestertown		4c. County of Death Kent		
Funeral Director	5. Social Security Number 219-36-7083	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) February 18, 1905		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland		10b. County Kent		10c. City, Town or Location Rock Hall		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number East Neck Island Road				10f. Zip Code 21661		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) School Teacher		16b. Kind of Business/Industry Education				
	17. Father's Name (First, Middle, Last) James Wood				18. Mother's Name (First, Middle, Maiden Surname) Nellie Sappington				
	19a. Informant's Name/Relationship (Type, Print) Rose Ellen Reihl/Niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5310 Skinners Neck Road, Rock Hall, Maryland 21661				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Wesley Cemetery/June 29, 1996		20c. Location - City or Town, State Rock Hall, Maryland				
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>INTRA CEREBRAL HEMORRHAGE</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D-13824		29d. Date signed (Month, Day, Year) 6-26-96			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. John Seymour, 122 Speer Road, Chestertown, Maryland 21620									
31. Date filed (Month, Day, Year) JUN 26 '96		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

perm. 1. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

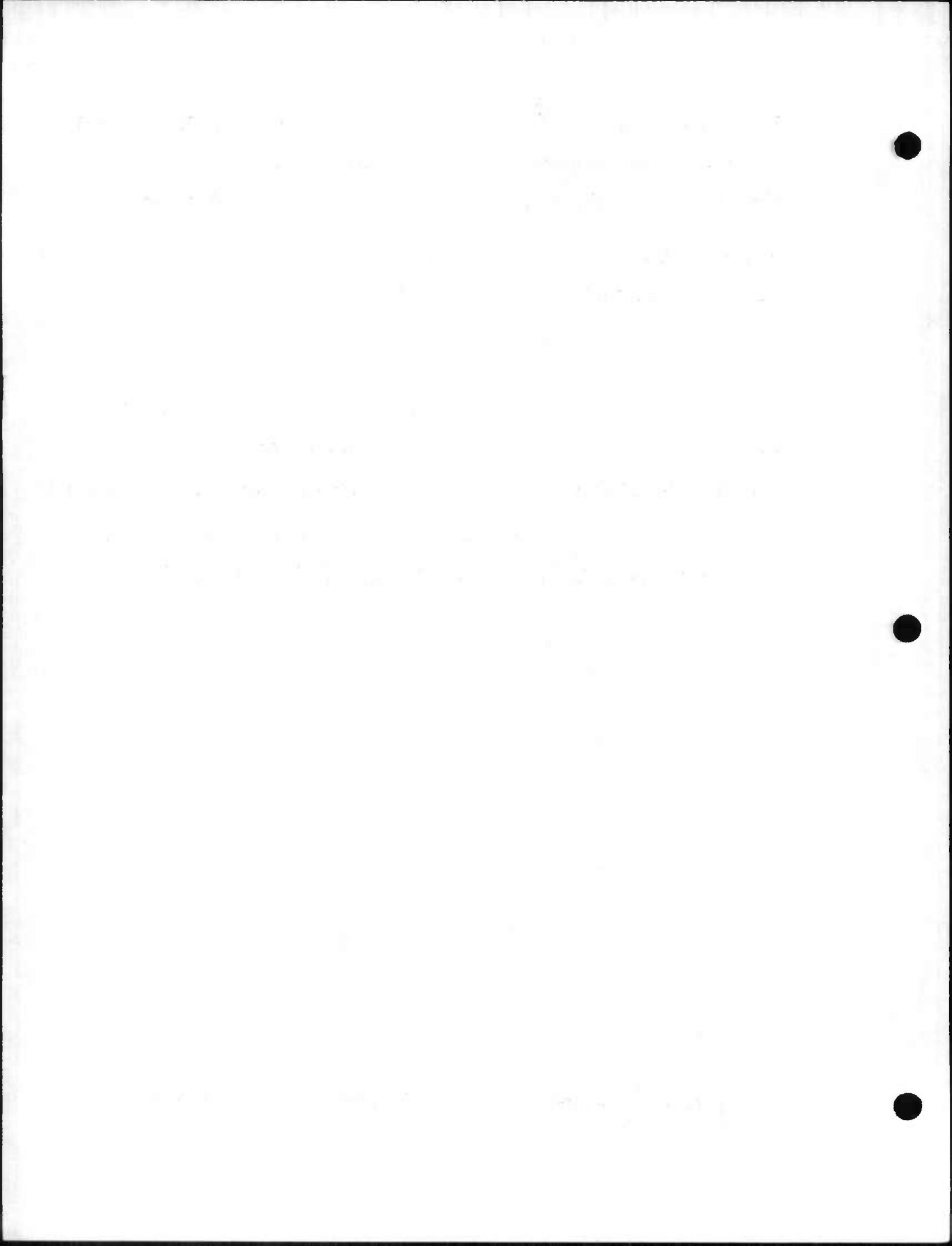
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25644

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARY ELLEN RICHARDSON</b>				2. Date of Death Month <b>JUNE</b> Day <b>6</b> Year <b>1996</b>		3. Time of Death <b>9:45 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>CHESTER NURSING &amp; REHABILITATION CHESTER TOWN</b>				4b. City, Town, or Location of Death <b>KENT</b>		4c. County of Death <b>KENT</b>		
Funeral Director	5. Social Security Number <b>213-147112</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>78</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>6-16-17</b>		
	9. Birthplace (State or Foreign Country) <b>MD.</b>		10a. State <b>MD.</b>		10b. County <b>KENT</b>		10c. City, Town or Location <b>CHESTER TOWN</b>		
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>8533 CAULK FIELD RD.</b>		10f. Zip Code <b>21620</b>		10g. Citizen of What Country? <b>U.S.A</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify <b>BLACK</b>		
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>0-11</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Food PROCESSOR</b>		16b. Kind of Business/Industry <b>FACTORY</b>				
	17. Father's Name (First, Middle, Last) <b>OSCAR GRINNELL, SR.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Lillian UNK.</b>		19a. Informant's Name/Relationship (Type, Print) <b>FRANKLIN C. BUTLER, SR.</b>				
Physician /Medical Examiner	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8533 CAULK FIELD ROAD CHESTER TOWN MD 21620</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ASBURY CEM.</b>		20c. Location - City or Town, State <b>6/14/96 CHESTER TOWN, MD.</b>		
	21. Signature of Funeral Service Licensee <b>Kenneth Walley</b>		22. Name and Address of Facility <b>WALLET FUNERAL HOME CHESTER TOWN, MD. 21620</b>						
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>Cardiopulmonary Arrest</b> Due to (or as a consequence of): b. <b>Hypertension</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chelexia, Severe Rheumatoid Arthritis</b> <b>ASCD, H/O CHF, H/O Hypertension</b> <b>H/O CVA, Depression</b>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	26. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		27. Date of Injury (Month, Day Year) <b>None</b>		27b. Time of Injury <b>M</b>		27c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Physician/Medical Examiner	27d. Describe how injury occurred		27e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		27f. Location (Street and Number or Rural Route Number, City or Town, State)				
	28a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28b. Signature and title of certifier <b>J.C. Arnold MD</b>		28c. License number <b>D23889</b>		28d. Date signed (Month, Day, Year) <b>6/13/96</b>		
State Registrar	29. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JOHN C. ARRABAL 948 WASHINGTON AVE. CHESTER TOWN MD.</b>		30. Date filed (Month, Day, Year) <b>JUN 19 '96</b>		31. Registrar's Signature <b>Julia Davidson-Randall</b>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

96 25645

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Sandra Olivia Schauber

2. Date of Death

Month Day Year  
June 30, 1996

3. Time of Death

8:05 a.m.

Funeral  
Director

4e. Facility Name (If not institution, give street and number)

1122 Price Station Road (At Home)

4b. City, Town, or Location of Death

Price

4c. County of Death

Queen Annes

5. Social Security Number

212-40-8605

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

53 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
December 22, 1942

9. Birthplace (State or Foreign Country)

Chestertown, MD

Usual Residence of Decedent

10a. State

Maryland

10b. County

Queen Annes

10c. City, Town or Location

Price

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1122 Price Station Road

10f. Zip Code

21656

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (14 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Postmistress

16b. Kind of Business/Industry

U.S. Postal Service

17. Father's Name (First, Middle, Last)

Roland Edward LeCates

18. Mother's Name (First, Middle, Maiden Surname)

Helen Gertrude Brown

19a. Informant's Name/Relationship (Type, Print)

Albert A. Schauber/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1122 Price Station Road, Price, Maryland 21656

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Chester Cemetery/July 3, 1996

Date

20c. Location - City or Town, State

Chestertown, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fellows, Helfenbein & Newman Funeral Home, P.A.  
130 Speer Road, Chestertown, Maryland 2162023e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Ca of breast with metastasis

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

8 years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
8 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29e. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 21313

29d. Date signed (Month, Day, Year)

7/1/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Kin K. Wun, 223 High Street, Chestertown, Maryland 21620

31. Date filed (Month, Day, Year)

JUL 1 '96

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25646

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Estelle Sydney Saulnier

2. Date of Death

June 23, 1996

3. Time of Death

9:50 a.m.

4a. Facility Name (If not institution, give street and number)

Heron Point

4b. City, Town, or Location of Death

Chestertown

4c. County of Death

Kent

Funeral  
Director

5. Social Security Number

131-26-2512

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 15, 1905

9. Birthplace (State or Foreign Country)

Pinsk, Belarusse

Usual Residence of Decedent

10e. State  
Maryland

10b. County

Kent

10c. City, Town or Location

Chestertown

10d. Inside City Limits

XX Yes 2 ☐ No

10e. Street and Number

230 Heron Point

10f. Zip Code

21620

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Administrative Assistant

16b. Kind of Business/Industry

Private/Economist

17. Father's Name (First, Middle, Last)

Morris Siegel

18. Mother's Name (First, Middle, Maiden Surname)

Ida CherChuk

19a. Informant's Name/Relationship (Type, Print)

Alice L. Ritchie/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

23237 Cedar Point Road, Chestertown, Maryland 21620

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Cremation Center/June 24, 1996 Stevensville, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fellows, Helfenbein & Newnam Funeral Home, P.A.  
130 Speer Road, Chestertown, Maryland 21620

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PANCREATIC CANCER

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 mo.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SENILE DEMENTIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D41587

29d. Date signed (Month, Day, Year)

6/24/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Helen A. Noble, MD, 122 Speer Road, Chestertown, Maryland 21620

31. Date filed (Month, Day, Year)

JUN 24 '96

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25647

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Willard Lester Smith				2. Date of Death Month Day Year June 16, 1996		3. Time of Death 1:50 a.m.	
	4a. Facility Name (If not institution, give street and number) Magnolia Hall, Inc.				4b. City, Town, or Location of Death Chestertown		4c. County of Death Kent	
Funeral Director	5. Social Security Number 215-20-0935		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (in yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) December 25, 1924	
	10a. State Maryland		10b. County Kent		10c. City, Town or Location Kennedyville		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 30189 Duck Puddle Road				10f. Zip Code 21645		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farming		18b. Kind of Business/Industry Agricultural			
	17. Father's Name (First, Middle, Last) Daniel H. Smith				18. Mother's Name (First, Middle, Maiden Surname) Grace Dodson			
	19a. Informant's Name/Relationship (Type, Print) Margaret Smith/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30189 Duck Puddle Road, Kennedyville, Maryland 21645			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Galena Cemetery/June 19, 1996		20c. Location - City or Town, State Galena, Maryland			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Fellows, Helfenbein & Newman Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620			
	23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Respiratory Failure</u> Due to (or as a consequence of): b. <u>Metastatic Carcinoma to Liver</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Hypertension, Abdominal Aortic Aneurysm</u>							
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <u>none</u>		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number J23889		29d. Date signed (Month, Day, Year) June 17, 1996	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. John C. Arrabal, 948 Washington Avenue, Chestertown, Maryland 21620							
State Registrar	31. Date filed (Month, Day, Year) JUN 18 '96		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25648

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth Eleanor Shriver

2. Date of Death

June 25, 1996

3. Time of Death

7:00 a.m.

4a. Facility Name (If not institution, give street and number)

Chestertown Nursing and Rehabilitation Cntr.

4b. City, Town, or Location of Death

Chestertown

4c. County of Death

Kent

Funeral  
Director

5. Social Security Number

216-44-7106

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

January 8, 1911

9. Birthplace (State or Foreign Country)

Baltimore City, MD

Usual Residence of Decedent

10a. State

Maryland

10b. County

Kent

10c. City, Town or Location

Chestertown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

21710 Bay Shore Road

10f. Zip Code

21620

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker/Caregiver

16b. Kind of Business/Industry

Domestic/Own Home

17. Father's Name (First, Middle, Last)

Elmer G. Arnold-Runge

18. Mother's Name (First, Middle, Maiden Surname)

Grace Margaret Towers

19a. Informant's Name/Relationship (Type, Print)

Charmayne Dierker/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21710 Bay Shore Road, Chestertown, Maryland 21620

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Louden Park Cemetery/June 27, 1996 Baltimore, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Fellows, Helfenbein &amp; Newman Funeral Home, P.A.

130 Spier Road, Chestertown, Maryland 21620

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode or type of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. pneumonia

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. chronic lymphocytic leukemia

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

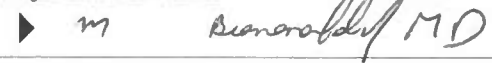
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D33514

29d. Date signed (Month, Day, Year)

June 25, 1996

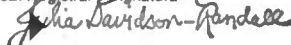
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Michael Bienenfeld, 100 Brown Street, Chestertown, Maryland 21620

31. Date filed (Month, Day, Year)

JUN 26 '96

32. Registrar's Signature


State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25649

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Harriett Louisa Skipp				2. Date of Death Month Day Year June 25, 1996		3. Time of Death 12:15 a.m.	
	4a. Facility Name (If not institution, give street and number) Heron Point				4b. City, Town, or Location of Death Chestertown		4c. County of Death Kent	
Funeral Director	5. Social Security Number 216-18-2700		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 12, 1915	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Kent		10c. City, Town or Location Chestertown			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number Hynson's Gift Farm/John Hanson Road				10f. Zip Code 21620		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife			16b. Kind of Business/Industry Domestic/Own Home	
17. Father's Name (First, Middle, Last) Richard Hynson Rogers				18. Mother's Name (First, Middle, Maiden Surname) Hallie Wescott				
19a. Informant's Name/Relationship (Type, Print) Stefan R. Skipp				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 924 Placid Court, Arnold, Maryland 21012				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Pauls Cemetery		Date		20c. Location - City or Town, State Fairlee, Maryland		
21. Signature of Funeral Service Licensee Marvin V. Williams Jr.				22. Name and Address of Facility MARVIN V. WILLIAMS JR. 130 SPEER RD FELLOWS, HELFENSON, NEWNAM F.H. CHESTERTOWN MD				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. OVARIAN CANCER Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 3 months
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ALZHEIMERS TYPE DEMENTIA						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Helen Noble MD				29c. License number D41587		29d. Date signed (Month, Day, Year) 6-25-96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Helen Noble, 122 Speer Road, Chestertown, Maryland 21620								
31. Date filed (Month, Day, Year) JUN 26 '96		32. Registrar's Signature Julia Davidson-Randall						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

12

State  
Registrar






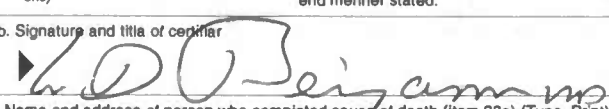

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25650

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Samuel Robert Tucker				2. Date of Death Month Day Year June 10, 1996				3. Time of Death 4:08 p.m.	
	4a. Facility Name (If not institution, give street and number) Kent & Queen Annes Hospital				4b. City, Town, or Location of Death Chestertown				4c. County of Death Kent	
Funeral Director	5. Social Security Number 165-12-2325		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) December 14, 1921		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Kent		10c. City, Town or Location Rock Hall				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 5548 Main Street				10f. Zip Code 21661		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collega (1-4or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Insurance Agent			16b. Kind of Business/Industry Insurance		
	17. Father's Name (First, Middle, Last) Thomas Adkins Tucker				18. Mother's Name (First, Middle, Maiden Surname) Margaret Ella Burgess					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mary McClure Tucker				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5548 Main Street, Rock Hall, Maryland 21661					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Wesley Chapel Cemetery/June 14, 1996		Data Rock Hall, Maryland		20c. Location - City or Town, State			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Fellows, Helfenbein & Newman Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21600					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute myocardial infarction Due to (or as a consequence of):								Approximate Interval Between Onset and Death < 2 hr	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. carcinoma of lung radiation pneumonia, hx				23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 		29c. License number D16488		29d. Date signed (Month, Day, Year) June 11, 1996	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Wayne D. Benjamin, 100 Brown Street, Chestertown, Maryland 21620				31. Date filed (Month, Day, Year) JUN 12 '96				32. Registrar's Signature 	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25651

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Raymond LeRoy Thomas</b>				2. Date of Death Month <b>June</b> Day <b>29</b> Year <b>1996</b>				3. Time of Death <b>1435 hrs</b>	
	4a. Facility Name (If not institution, give street and number) <b>6215 Sudlersville Road ( AT Home )</b>				4b. City, Town, or Location of Death <b>Sudlersville</b>				4c. County of Death <b>Queen Anne's</b>	
Funeral Director	5. Social Security Number <b>221-20-2635</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>61</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>August 3, 1934</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent				10a. State <b>Maryland</b>		10b. County <b>Queen Anne's</b>		10c. City, Town or Location <b>Sudlersville</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <b>6215 Sudlersville Road</b>		10f. Zip Code <b>21668</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>Korea</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)	
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Iron Worker</b>				16b. Kind of Business/Industry <b>Construction</b>				17. Father's Name (First, Middle, Last) <b>Reynolds M. Thomas</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>Madeline McMullen</b>				19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Joyce Strahorn Thomas</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21668</b> <b>6215 Sudlersville Road, Sudlersville, Maryland</b>	
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Capitol Crematory</b>		Date <b>July 1, 1996</b>		20c. Location - City or Town, State <b>Dover, Delaware</b>		21. Signature of Funeral Service Licensee <b>William L. King Jr.</b>	
	22. Name and Address of Facility <b>Micahael J. Ambruso, F.D.</b> <b>1175 S. State Street, Dover, Delaware 19901</b>		23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Metastatic Cancer - primary</b> <b>Sight unknown</b>				Approximate Interval Between Onset and Death <b>DX 5/96</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)	
To Be Completed by Physician/Medical Examiner	28b. Time of Injury <b>M</b>				28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No				28d. Describe how Injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <b>Michael J. Bradley</b>				29c. License number <b>C2-2269</b>				29d. Date signed (Month, Day, Year) <b>7-1-96</b>	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Michael J. Bradley MD 1342 S. Gov Ave Dover DE 19901</b>				31. Date filed (Month, Day, Year) <b>MAY 8 '96</b>				32. Registrar's Signature <b>John Davidson-Randall</b>	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25652

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles Richard Wheat				2. Date of Death Month Day Year June 25, 1996		3. Time of Death 7:17 a.m.	
	4a. Facility Name (If not institution, give street and number) Kent & Queen Annes Hospital				4b. City, Town, or Location of Death Chestertown		4c. County of Death Kent	
Funeral Director	5. Social Security Number 214-32-2160	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 63 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) August 4, 1932		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Kent		10c. City, Town or Location Chestertown			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 102 Manor Avenue				10f. Zip Code 21620		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1955-1963		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Postal Carrier			16b. Kind of Business/Industry U.S. Postal Service	
17. Father's Name (First, Middle, Last) Elwood Wheat				18. Mother's Name (First, Middle, Maiden Surname) Grace Parsons				
19a. Informant's Name/Relationship (Type, Print) Nancy Wheat/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 Manor Avenue, Chestertown, Maryland 21620				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cramation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) St. Pauls Cemetery/June 28, 1996		20c. Location - City or Town, State Chestertown, Maryland		
21. Signature of Funeral Service Licensee <i>Gary B. Sullivan</i>				22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Acute Myocardial Infarction</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <i>minutes</i>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Old CVA with Rt Hemiparesis</i>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>K. K. Wun, M.D.</i>		29c. License number D21313		29d. Date signed (Month, Day, Year) 6/25/96
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kin K. Wun, 223 High Street, Chestertown, Maryland 21620								
31. Date filed (Month, Day, Year) JUN 26 '96				32. Registrar's Signature <i>J. Davidson-Randall</i>				

Baltimore, Maryland 21215-0020

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



96 25653

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>AUGUSTINE W. AFFAYROUX</b>				2. DATE OF DEATH MONTH <b>AUGUST</b> DAY <b>27</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>2:00 P M</b>	
4. SOCIAL SECURITY NUMBER <b>215-03-1156</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>82</b> YRS.	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	7. DATE OF BIRTH (Month, Day, Year) <b>September 14, 1913</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Lorien-Frankford Nursing Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH <b>N/A</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Fullerton</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>7 Kinwall Place Apt. TA</b>	
10f. ZIP CODE <b>21236</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II 1944-1945</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Groundskeeper</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Baltimore City Gov't</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Francis Affayroux</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Anna Fousek</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Rose M. Affayroux/Wife</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7 Kinwall Place Apt TA Baltimore, Md. 21236</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Hilltop Service Corporation 8/30/96</b>		20c. LOCATION — City or Town, State <b>Towson, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Brian A. Willem</b>				22. NAME AND ADDRESS OF FACILITY <b>Leonard J. Ruck Funeral Home, Inc. 5305 Harford Road Baltimore, Maryland 21214</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Chronic obstructive Pulmonary Disease</b> DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <b>YEARS</b>							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Atherosclerotic Cardiovascular Disease</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Fredrick S. Sirkis M.D.</b>				29c. LICENSE NUMBER <b>D22645</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/28/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>FREDRICK S. SIRKIS M.D. 7151 HOLABIRD AVE. BALTO, MD 21222</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 29 1996</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Rodriguez</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed without delay. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25654

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

George

Atkins JR.

2. Date of Death

Month

Day

Year

Aug.

23,

1996

3. Time of Death

22:12PM

4a. Facility Name (If not institution, give street and number)

University Hospital S.T.U

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

215-82-5102

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

31

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Oct. 4, 1964

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

559 Baker St.

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Negro

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Unemployed

16b. Kind of Business/Industry

Never worked

17. Father's Name (First, Middle, Last)

George Atkins Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mary Sue McCaskill

19a. Informant's Name/Relationship (Type, Print)

Mrs. Diane Atkins-Harcum

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2626 Robb St. Balto. Md. 21218

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion

Date

9/4/96

20c. Location - City or Town, State

Lansdowne, Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home  
2323 W. North Ave. Balto. Md. 21216

23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Gunshot Wounds

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☒ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

8-23-96

28b. Time of Injury

unk

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Subject was shot

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Street

28f. Location (Street and Number or Rural Route Number, City or Town, State)

559 Baker Street

Baltimore City, Maryland

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dennis J. Chute m

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

August 24, 1996

30. Name and address of person who completed cause of death (item 23e) (Type, Print)

Dennis J. Chute m

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 29 1996

32. Registrar's Signature

John Michael Roberts

State Registrar

Baltimore, Maryland 21215-0020

Deaths ages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25655

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>William B. Allen</b>				2. Date of Death Month <b>August</b> Day <b>27</b> Year <b>1996</b>		3. Time of Death <b>12:15AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Chesapeake Manor Nursing Home</b>				4b. City, Town, or Location of Death <b>Arnold</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>275-26-5536</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) <b>75 Yrs.</b>		8. Date of Birth (Month, Day, Year) <b>May 29, 1921</b>	
	9. Birthplace (State or Foreign Country) <b>Ohio</b>		10. Usual Residence of Decedent		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>	
To Be Completed by Funeral Director	10a. State <b>Md</b>		10b. County <b>City</b>		10c. City, Town or Location <b>Baltimore City</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>1715 Jackson Street</b>				10f. Zip Code <b>21230</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b>		12. Collage (1-4 or 5+) <b>0</b>		13. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Sanitation Worker</b>		14. Kind of Business/Industry <b>Baltimore City</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b>				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Sanitation Worker</b>		17. Kind of Business/Industry <b>Baltimore City</b>	
	17. Father's Name (First, Middle, Last) <b>Benjamin Allen</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Vidas Unknown</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Evelyn Allen / Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1715 Jackson Street Baltimore, Md. 21230</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery</b>		20c. Date <b>8/29/96</b>		20d. Location - City or Town, State <b>Brooklyn Park, MD</b>	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>McCully Funeral Home of South Baltimore</b> <b>130 E. Fort Ave. Baltimore, Md. 21230</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>Sepsis</b> Due to (or as a consequence of): b. <b>Advanced Decubitus ulcers</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Advanced Alzheimer's Disease</b>							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) <b>8-28-96</b>				
28b. Time of Injury <b>M</b>				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>Wynne M. Attending Doctor</b>				
29c. License number <b>D 21684</b>				29d. Date signed (Month, Day, Year) <b>8-28-96</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>C.V. CYRIAC M.D. 1600 CRAIN HWY #106, GLENBURNIA, MD 21061</b>								
31. Date filed (Month, Day, Year) <b>AUG 29 1996</b>				32. Registrar's Signature <i>[Signature]</i>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

96 25656

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Peter Joseph Amann</b>				2. Date of Death Month <b>August</b> Day <b>24</b> Year <b>1996</b>		3. Time of Death <b>12:45 A</b>	
	4a. Facility Name (If not institution, give street and number) <b>FALL STON GENERAL HOSPITAL</b>				4b. City, Town, or Location of Death <b>FALLSTON MD</b>		4c. County of Death <b>HARFORD</b>	
Funeral Director	5. Social Security Number <b>213-07-9894</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>AUG. 13, 1911</b>	9. Birthplace (State or Foreign Country) <b>PA.</b>
	Usual Residence of Decedent				10a. State <b>MD.</b>		10b. County <b>BALTIMORE</b>	
10c. City, Town or Location <b>DUNDALK</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>2907 DUNMORE RD.</b>		10f. Zip Code <b>21222</b>
10g. Citizen of What Country? <b>U.S.A.</b>				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>FOREMAN</b>		16b. Kind of Business/Industry <b>STEEL</b>
17. Father's Name (First, Middle, Last) <b>FRANK AMANN</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ELIZABETH ROBERTS</b>		19a. Informant's Name/Relationship (Type, Print) <b>JOANNE PETERS</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1106 HENDERSON RD. BELAIR, MD. 21014</b>
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>OAK LAWN CEMETERY</b>		20c. Location - City or Town, State <b>8/26/96 BALTIMORE, MD.</b>		20d. Date
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>BRADLEY ASHTON FUNERAL HOME, INC. 2134 WILLOW SPRING RD. BALTO. MD. 21222</b>				23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>CONGESTIVE HEART FAILURE</b> <b>BACTERIAL ENDOCARDITIS</b> <b>AORTIC VALVE REPLACEMENT</b> <b>AORTIC STENOSIS</b>
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ISCHEMIC HEART DISEASE</b>				23c. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				23d. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24c. Approximate Interval Between Onset and Death <b>28 DAYS</b> <b>28 DAYS</b> <b>1 1/2 YEARS</b> <b>5 YEARS</b>
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				26a. Date of Injury (Month, Day, Year)
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>Andrew Nowakowski MD</b>				29c. License number <b>D09086</b>
29d. Date signed (Month, Day, Year) <b>AUG-UST 25, 1996</b>				30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>ANDREW NOWAKOWSKI MD 125 N. MAIN ST. BEL AIR, MD 21014</b>				31. Date filed (Month, Day, Year) <b>AUG 29 1996</b>
32. Registrar's Signature 				33. State Registrar				34. DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



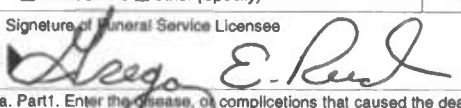
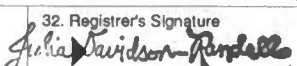
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25657

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Gladys BROOKS</b>				2. Date of Death Month Day Year <b>August 26, 1996</b>		3. Time of Death <b>8:00 PM</b>												
	4a. Facility Name (If not institution, give street and number) <b>Franklin Square Hospital</b>				4b. City, Town, or Location of Death <b>Rossville</b>		4c. County of Death <b>Baltimore</b>												
Funeral Director	5. Social Security Number <b>212-22-4025</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>69</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Nov. 14, 1926</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>											
	Usual Residence of Decedent																		
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Perry Hall</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												
	10e. Street and Number <b>3505 Parkfalls Drive</b>				10f. Zip Code <b>21236</b>		10g. Citizen of What Country? <b>United States</b>												
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>												
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 Years</b> College (1-4 or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Accountant</b>		16b. Kind of Business/Industry <b>McKesson Drugs</b>														
	17. Father's Name (First, Middle, Last) <b>George Eigner</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Cassandra Mihn</b>														
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Gail I. Robusto/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3505 Parkfalls Drive Perry Hall, Maryland 21236</b>														
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gdns of Faith Cemetery</b>		Date <b>8/30/96</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>												
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222</b>														
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																		
	<table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>Pneumonia, Sepsis.</b> Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death <b>3 Days</b></td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</td> <td>b. <b>Aspiration.</b> Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c.  Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.  Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td colspan="2">Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. <b>Pneumonia, Sepsis.</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <b>3 Days</b>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. <b>Aspiration.</b> Due to (or as a consequence of):		c. Due to (or as a consequence of):		d. Due to (or as a consequence of):		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Immediate Cause (Final disease or condition resulting in death)	a. <b>Pneumonia, Sepsis.</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <b>3 Days</b>																	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. <b>Aspiration.</b> Due to (or as a consequence of):																		
	c. Due to (or as a consequence of):																		
	d. Due to (or as a consequence of):																		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																		
23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No											
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)															
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred											
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)															
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																			
29b. Signature and title of certifier 				29c. License number <b>R D 1897</b>		29d. Date signed (Month, Day, Year) <b>8/26/96 8:40pm</b>													
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Howard Farrington 9000 Franklin Square Dr. Baltimore, Maryland 21237</b>																			
31. Date filed (Month, Day, Year) <b>AUG 29 1996</b>				32. Registrar's Signature 															

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

10





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State of Maryland / Department of Health and Mental Hygiene

96 25658

Film G738 item 1 per DR. 8-29-96 rja

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <del>BARRETT PRICE</del> Price Albert Barrett						2. Date of Death Month Day Year August 24 1996		3. Time of Death 13:52																	
	4a. Facility Name (If not Institution, give street and number) THE JOHNS HOPKINS HOSPITAL						4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death N/A																	
Funeral Director	5. Social Security Number 216-62-3706		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 41 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 9, 1954		9. Birthplace (State or Foreign Country) Missouri																	
	Usual Residence of Decedent																									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Dundalk				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																	
	10e. Street and Number 3144 C Wallford Drive				10f. Zip Code 21222		10g. Citizen of What Country? United States																			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White																		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 9 Years				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Disabled			16b. Kind of Business/Industry N/A																		
	17. Father's Name (First, Middle, Last) William Jacob Barrett						18. Mother's Name (First, Middle, Maiden Surname) Kay Miller																			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Karen A. Barrett/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3144 C Wallford Drive Dundalk, Maryland 21222																					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Mem. Cem. 8/27/96		Date 8/27/96		20c. Location - City or Town, State Middle River, MD																			
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222																					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																									
	<table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>Bronchectasis</td> <td>Due to (or as a consequence of):</td> <td>6 months</td> </tr> <tr> <td>b.</td> <td>Acute Respiratory Failure</td> <td>Due to (or as a consequence of):</td> <td>1 week</td> </tr> <tr> <td>c.</td> <td>Acute Respiratory Acidosis</td> <td>Due to (or as a consequence of):</td> <td>24 hrs</td> </tr> <tr> <td>d.</td> <td></td> <td></td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	a.	Bronchectasis	Due to (or as a consequence of):	6 months	b.	Acute Respiratory Failure	Due to (or as a consequence of):	1 week	c.	Acute Respiratory Acidosis	Due to (or as a consequence of):	24 hrs	d.		
Immediate Cause (Final disease or condition resulting in death)	a.	Bronchectasis	Due to (or as a consequence of):	6 months																						
	b.	Acute Respiratory Failure	Due to (or as a consequence of):	1 week																						
	c.	Acute Respiratory Acidosis	Due to (or as a consequence of):	24 hrs																						
	d.																									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cystic Fibrosis, Non-Delta 508								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																		
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																		
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)																								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred																		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																										
29b. Signature and title of certifier <i>Thomas W. Shields M.D.</i>				29c. License number N 9475			29d. Date signed (Month, Day, Year) August 24, 1996																			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) THOMAS W. SHIELDS, MD N 9475																										
31. Date filed (Month, Day, Year) AUG 29 1996		32. Registrar's Signature <i>[Signature]</i>																								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25659

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLES WILLIAM BERTHOLDT

2. Date of Death

Month Day Year  
August 28, 1996

3. Time of Death

8:09 AM

4a. Facility Name (If not institution, give street and number)

HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE CITY

Funeral  
Director

5. Social Security Number

220-12-9538

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JAN 29, 1927

9. Birthplace (State or Foreign Country)

BALTIMORE, MD

Usual Residence of Decedent

10a. State

MD

10b. County

ANNE ARUNDEL

10c. City, Town or Location

LINTHICUM

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

11 MANSION ROAD

10f. Zip Code

21090

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12TH GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TEAMSTER

16b. Kind of Business/Industry

TRUCKING COMPANY

17. Father's Name (First, Middle, Last)

CHARLES ROBERT BERTHOLDT

18. Mother's Name (First, Middle, Maiden Surname)

ELIZABETH EMMA KELLY

19a. Informant's Name/Relationship (Type, Print)

DOROTHY BERTHOLDT (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11 MANSION ROAD - LINTHICUM, MD 21090

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

LOUDON PARK CEMETERY

Date

8/31/96

20c. Location - City or Town, State

BALTIMORE

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HUBBARD FUNERAL HOME, INC.

4107 WILKENS AVENUE-BALTIMORE, MD 21229

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE RESPIRATORY DISTRESS SYNDROME 13 DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. PNEUMONIA 13 DAYS

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION / CONGESTIVE HEART FAILURE

INSULIN DEPENDENT DIABETES MELLITUS

ATRIAL FIBRILLATION / HYPERCHOLESTEROLEMIA

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

AS2441614-44

29d. Date signed (Month, Day, Year)

August 28, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FER EREN, M.D. 3001 SOUTH HANOVER STREET BALTIMORE, MARYLAND 21230

31. Date filed (Month, Day, Year)

AUG 29 1996

32. Registered Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25660

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Viola M. Bauden

2. Date of Death

Month 8 Day 25 Year 96 7AM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

320 Frank Moreland Place

4b. City, Town, or Location of Death

Lothian

4c. County of Death

Anne Arundel

5. Social Security Number

135-03-1234

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

Month, Day, Year

8-4-11

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Lothian

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

320 Frank Moreland Place

10f. Zip Code

20711

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

NA

17. Father's Name (First, Middle, Last)

Julius Heerwagen

18. Mother's Name (First, Middle, Maiden Surname)

Anna Fell

19a. Informant's Name/Relationship (Type, Print)

Linda A. Ellis

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

320 Frank Moreland PL Lothian, Md 20711

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

8/29/96

20c. Location - City or Town, State

Catonville, Md.

21. Signature of Funeral Service Licensee

Charles E. Dick III

22. Name and Address of Facility

House of Nick F/H 1922 Forest Dr Annapolis Md.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Dementia

Due to (or as a consequence of):

b.

Diabetes

Due to (or as a consequence of):

c.

Hypertension

Due to (or as a consequence of):

d.

Approximate interval between Onset and Death

1 year +

5 years +

5 years +

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Harvey J. Steinfeld MD

29c. License number

D05158

29d. Date signed (Month, Day, Year)

8/28/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HARVEY STEINFELD, SHADYSIDE MD 20764

31. Date filed (Month, Day, Year)

AUG 29 1996

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



jhm

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25661

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MILTON

BRADLEY

2. Date of Death  
Month Day Year

AUGUST 24, 1996

3. Time of Death

22:30 PM

4a. Facility Name (If not institution, give street and number)

5633 TORQUE ROAD

4b. City, Town, or Location of Death

Linthicum

4c. County of Death

ANNE ARUNDEL

Funeral  
Director

5. Social Security Number

220-14-8776

6. Sex

15 M 2 F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

June 28, 1926 Maryland

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10e. State  
Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Linthicum

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

5633 Torque Road

10f. Zip Code

21090

10g. Citizen of What Country?

United States

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes 2 No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Machinist

16b. Kind of Business/Industry

Tool &amp; Die Industry

17. Father's Name (First, Middle, Last)

Robert Earl Bradley

18. Mother's Name (First, Middle, Maiden Surname)

Florence Gassaway

19a. Informant's Name/Relationship (Type, Print)

Geraldine Bradley, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5633 Torquay Reach Linthicum, MD 21090

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Meadowridge Memorial 8/28/96 Dorsey, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ambrose Funeral Home of Lansdowne

2719 Hammonds Ferry Road 21227

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

e. Intra-oral Gunshot Wound

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy  
performed?  
Limited to  
Head

1 Yes 2 No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 Yes 2 No

25. Was case referred to medical  
examiner?

XX Yes 2 No

26. Place of Death (Check only one)

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

Other:

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

5 Pending

Investigation

6 Could not be

determined

28a. Date of Injury

(Month, Day, Year)

8-24-96

28b. Time of

Injury

unk

M

28c. Injury at

Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

Home

28f. Location (Street and Number or Rural Route Number,  
City or Town, State) 5633 Torque Reach  
Linthicum, Maryland29a. Certifier  
(Check only  
one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

XX Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

AUGUST 25, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis J. Chute

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 29 1996

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0080

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

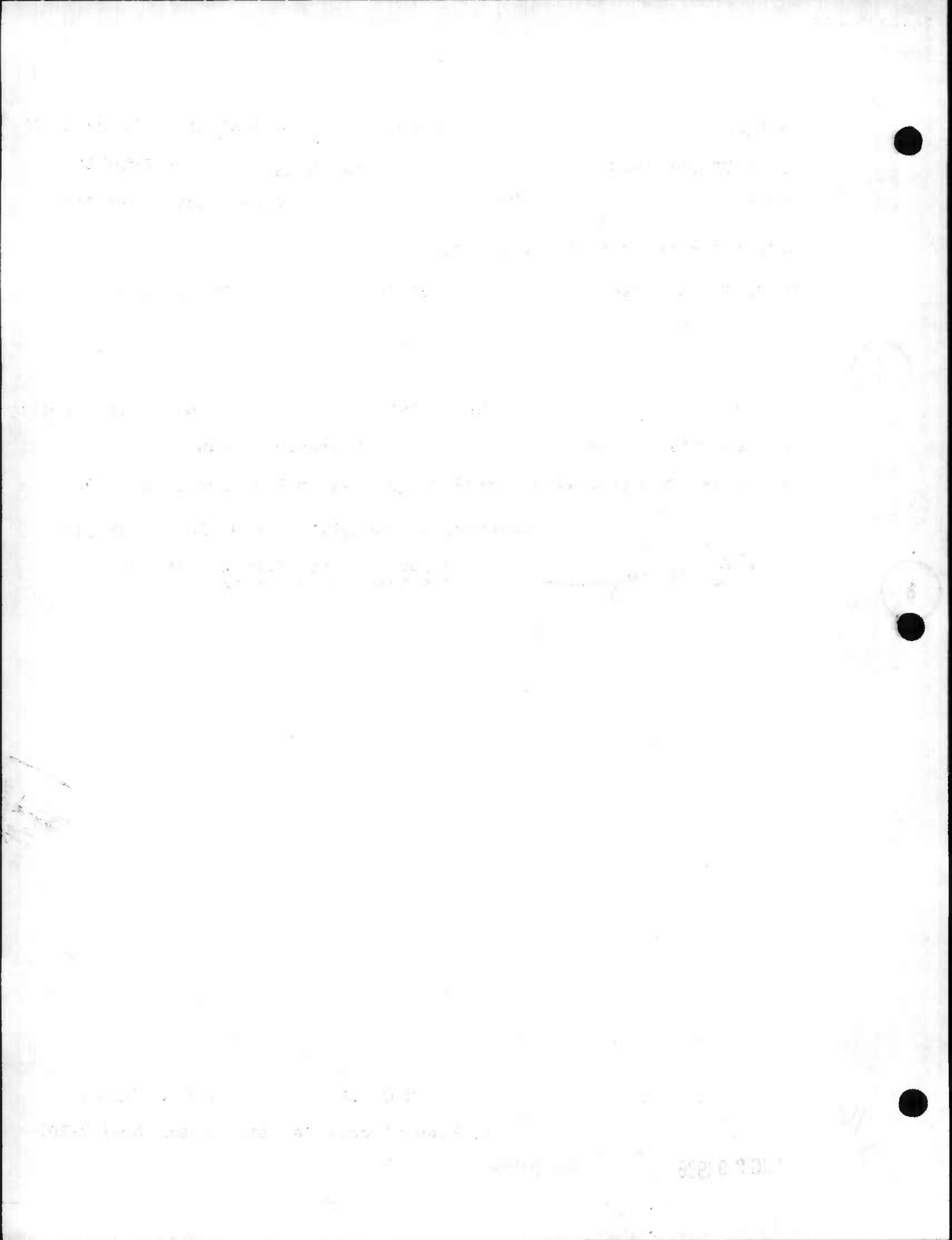
Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25662

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Granville John Childers

2. Date of Death

August 24 1996

3. Time of Death

6:35 PM

4e. Facility Name (If not institution, give street and number)

14 1/2 Delrey Avenue

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

218-12-7375

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 29, 1915

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

14 1/2 Delrey Avenue

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
7

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Shipping Clerk

16b. Kind of Business/Industry

Paper Mill

17. Father's Name (First, Middle, Last)

Ely Childers

18. Mother's Name (First, Middle, Maiden Surname)

Nancy Davis

19a. Informant's Name/Relationship (Type, Print)

Mildred Louise Childers/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14 1/2 Delrey Avenue Catonsville, MD 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Good Shepherd Cemetery 08/28/96

Date

20c. Location - City or Town, State

Ellicott City, MD

21. Signature of Funeral Service Licensee

Dawn F. McDonald

22. Name and Address of Facility

MacNabb Funeral Home, P.A.

301 Frederick Rd. Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Aortic aneurysm, previously ruptured

Due to (or as a consequence of):

c. Overall debilitation, Alzheimer's Dz.

Due to (or as a consequence of):

d. Urosepsis

5 yr  
years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Huefner

516 N. Rolling Rd. Suite 108 Baltimore, MD 21228

31. Date filed (Month, Day, Year)

AUG 29 1996

32. Registrar's Signature

Julia Anderson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be dated for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
item #25, filmg 738, 8/30/96, cyw, per md.

## Certificate of Death

Reg. No.

96 25663

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CLIFTON D. CRAWFORD Sr.</b>				2. Date of Death Month Day Year <b>AUGUST 23 1996</b>		3. Time of Death <b>5:45 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>GOOD SAMARITAN HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>214-38-0454</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>56</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>FEB. 18, 1940</b>		
	9. Birthplace (State or Foreign Country) <b>BALTIMORE, MD</b>		10a. State <b>MD</b>		10b. County <b>n/a</b>		10c. City, Town or Location <b>BALTIMORE</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>1342 STONEWOOD ROAD</b>		10f. Zip Code <b>21239</b>		10g. Citizen of What Country? <b>UNITED STATES</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>(1)</b> Collage (1-4 or 5+) <b>7 th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LABORER</b>		16b. Kind of Business/Industry <b>WAREHOUSE</b>		17. Father's Name (First, Middle, Last) <b>HENRY CRAWFORD</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>SARAH POWELL</b>	
19a. Informant's Name/Relationship (Type, Print) <b>MARY CRAWFORD</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1342 STONEWOOD ROAD, BALTIMORE, MD 21239</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ARBUTUS MEMORIAL PARK</b>		20c. Location - City or Town, State <b>8-28 ARBUTUS, MD</b>	
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>WM. C. MARCHFH.-1101 E. NORTH AVENUE</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>SHOCK</b>		Approximate Interval Between Onset and Death <b>3 DAYS</b>			
Immediate Cause (Final disease or condition resulting in death) <b>SHOCK</b>		Due to (or as a consequence of): <b>ETHYLENE GLYCOL INGESTION</b>		Due to (or as a consequence of):		Due to (or as a consequence of):		Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i> M.D.		29c. License number <b>RES 000</b>		29d. Date signed (Month, Day, Year) <b>AUG. 23, 1996</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ANN MECHERIKUNNEL, 5601, LOCH RAVEN BLVD, BALTIMORE.</b>		31. Date filed (Month, Day, Year) <b>AUG 29 1996</b>		32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25664

Film G738 item 4 per FH 8-29-96 rja

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Laverne Pauline Dillon</b>				2. Date of Death Month <b>August</b> Day <b>26</b> Year <b>1996</b>		3. Time of Death <b>6:30 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Glen Meadows Retirement Center</b>				4b. City, Town, or Location of Death <b>Glen Arm</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>212-12-2763</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>October 24, 1919</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Kingsville</b>	
To Be Completed by Funeral Director	10d. inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>906 Monica Circle</b>		10f. Zip Code <b>21087</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (14 or 5+) <input checked="" type="checkbox"/>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Publisher</b>		16b. Kind of Business/Industry <b>Fishing Magazine</b>			
	17. Father's Name (First, Middle, Last) <b>Charles Brittingham</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Pauline Senft</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Gayle L. Wolinski / Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same as 10e</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Loudon Park Cemetery</b>		Date <b>8/29/96</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>	
	21. Signature of Funeral Service Licensee <i>Ronald J. Ruck</i>		22. Name and Address of Facility <b>Leonard J. Ruck Funeral Home, Inc. 5305 Harford Road - Baltimore, Maryland</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>Arteriosclerotic Cerebrovascular Disease</b> Due to (or as a consequence of): b. <b>HYPERTENSION</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cerebral Arteriovenous Malformation</b>							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Walter Hepner</i>				29c. License number <b>D23450</b>		29d. Date signed (Month, Day, Year) <b>8/28/96</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Walter Hepner M/D. 3346 Paper Mill Road - Phoenix, Maryland 21131</b>								
31. Date filed (Month, Day, Year) <b>AUG 29 1996</b>		32. Registrar's Signature <i>Jane Davidson-Randall</i>						

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

FilmG738 item 1, 10e,17 per FH 8-29-96 rja

State of Maryland / Department of Health and Mental Hygiene

96 25665

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Dennis, Saunders L.</i>				2. Date of Death Month <i>August</i> Day <i>26</i> Year <i>1996</i>		3. Time of Death <i>11:10 am</i>	
	4a. Facility Name (If not institution, give street and number) <i>Mercy Hospital</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>Baltimore</i>	
Funeral Director	5. Social Security Number <i>252-40-9644</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) <i>67</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>AUG. 11, 1929</i>		9. Birthplace (State or Foreign Country) <i>GEORGIA</i>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <i>MD</i>	10b. County <i>n/a</i>	10c. City, Town or Location <i>BALTIMORE</i>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <i>S. 427 OXFORD COURT</i>			10f. Zip Code <i>21201</i>		10g. Citizen of What Country? <i>UNITED STATES</i>		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>BLACK</i>	
	15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>LABORER</i>		16b. Kind of Business/Industry <i>LOCAL 194</i>			
	17. Father's Name (First, Middle, Last) <i>WILLIE DENNIS</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>ADA DENNIS</i>					
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <i>STEWART L. FRAZIER</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1431 HOLBROOK ST., BALTIMORE, MD 21201</i>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>BALTIMORE CEMETERY</i>		20c. Location - City or Town, State <i>8+30 BALTIMORE, MD</i>			
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <i>WM C. MARCHFH.-1101 E. NORTH AVENUE</i>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <i>Hypoxemia</i> Due to (or as a consequence of): <i>Pleural Effusion</i> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
Medical Certification: To Be Completed by Physician/Medical Examiner	23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Renal Failure</i> <i>Hepatitis C</i>				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <i>N/A</i>		28b. Time of Injury <i>N/A</i> M		28c. Injury at Work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i>N/A</i>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>N/A</i>			
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <i>P10544</i>	
					29d. Date signed (Month, Day, Year) <i>August 26 1996</i>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Josh Dennis, MD 301 St Paul Place, Mary Medical Ctr. Baltimore, MD</i>							
31. Date filed (Month, Day, Year) <i>AUG 29 1996</i>				32. Registrar's Signature <i>[Signature]</i>				





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25666

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Floyd C. Davis</b>				2. Date of Death Month <b>August</b> Day <b>24</b> Year <b>1996</b>		3. Time of Death <b>3:30AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Union Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death <b>n/a</b>	
Funeral Director	5. Social Security Number <b>215-24-8027</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) <b>65</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>MAR. 12, 1931</b>	
	9. Birthplace (State or Foreign Country) <b>BALTIMORE, MD</b>		10a. State <b>MD</b>		10b. County <b>n/a</b>		10c. City, Town or Location <b>BLTO.</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>2821 KENNEDY AVENUE</b>		10f. Zip Code <b>21218</b>	
	10g. Citizen of What Country? <b>UNITED STATES</b>				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5th</b> College (14 or 5+) <b>-</b>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LABORER</b>				16b. Kind of Business/Industry <b>CONSTRUCTION</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>JOHN WILLIAM DAVIS SR.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>BETSY JACKSON</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>MARVA DAVIS</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2952 MOSHER CT. APT. 24, BALTIMORE, MD</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MARYLAND NATIONAL CEM.</b>		20c. Location - City or Town, State <b>LAUREL, MARYLAND</b>	
	21. Signature of Funeral Service Licensee <i>Blayne B. Harris</i>				22. Name and Address of Facility <b>WM. C. MARCHFH.-1101 E. NORTH AVENUE</b>			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. <b>Metastatic Lung CA</b> Due to (or as a consequence of): b. <b>Hypoxic encephalopathy</b> Due to (or as a consequence of): c. <b>Recurrent Malignant Pleural effusions</b> Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death <b>4yrs</b> <b>1 day</b> <b>2 1/2 mos.</b>			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred			
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Robert McKinney</i>			
To Be Completed by Physician/Medical Examiner	29c. License number <b>AT2438946</b>				29d. Date signed (Month, Day, Year) <b>8/24/96</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Robert McKinney, M.D. Union Memorial Hospital</b>				31. Data filed (Month, Day, Year) <b>AUG 29 1996</b>			
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature <i>J. Davidson-Randall</i>				33. State Registrar <b>201 E. University Pkwy Baltimore, MD 21218</b>			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25667

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DANIEL S DIGGS</b>				2. Date of Death Month: <b>AUG.</b> Day: <b>26.</b> Year: <b>1996</b>		3. Time of Death <b>5:45 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Church Home Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>242-24-2876</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>73</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 25, 1923</b>	9. Birthplace (State or Foreign Country) <b>North Carolina</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>764 N. Grantley St.</b>			10f. Zip Code <b>21229</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Negro</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Supervisor</b>			16b. Kind of Business/Industry <b>SSA</b>		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Aford Smith</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sallie Harris</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Williameta Diggs</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>764 N. Grantley St. Balto. Md. 21229</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>Entombment</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus</b>		20c. Location - City or Town, State <b>Balto. Co. Md.</b>		20d. Date <b>8/31/96</b>	
	21. Signature of Funeral Service Licensee <b>Joseph L. Russ</b>		22. Name and Address of Facility <b>Joseph L. Russ Funeral Home 2322 W. North Ave. Balto. Md. 21216</b>					
Physician /Medical Examiner	23a. Pertinent disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>UPPER GASTRO INTESTINAL BLEEDING</b> <b>STRESS GASTRITIS</b>							Approximate Interval Between Onset and Death <b>DAYS</b> <b>DAYS</b>
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
Medical Certification: To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier <b>A. R. Nazemi MD</b>				29c. License number <b>017322</b>		29d. Date signed (Month, Day, Year) <b>Aug. 26, 1996</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>A. R. NAZEMI, M.D. CHURCH HOSPITAL, BALTO. MD.</b>							
31. Date <b>AUG 29 1996</b>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



WRC  
96-4793-510  
UNK 96-189

ITEMS: 23 PART 1, 27, 28a-f, PER MED FILM 9-739 9/6/96 t.t  
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

96 25668

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ANTHONY JOSEPH DARPINO, JR.</b>			2. Date of Death Month <b>AUGUST</b> Day <b>23</b> Year <b>1996</b>		3. Time of Death <b>8:05 PM.</b>		
	4a. Facility Name (If not institution, give street and number) <b>Bon Secours Hospital</b>			4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>214-46-8995</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>49</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>Dec. 30, 1946</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Essex</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>1107-D Old Eastern Avenue</b>			10f. Zip Code <b>21221</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Wood Worker and Cabinet Maker</b>		16b. Kind of Business/Industry <b>Ready Built Products, Co.</b>			
	17. Father's Name (First, Middle, Last) <b>Anthony Joseph Darpino, Sr.</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Thelma Crawford</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Mr. Anthony J. Darpino, 3RD-SON</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>935 Long Cove Road, Glen Burnie, Maryland 21060</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Loudon Park Cemetery</b>		Data <b>8/28/96</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>McCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Baltimore, Md. 21225-1856</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>ACUTE ETHANOL AND MIXED DRUG INTOXICATION</b> Due to (or as a consequence of):  <b>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</b> a. _____ Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____							Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>23b. Did tobacco use contribute to the cause of death?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  <b>24a. Was an autopsy performed?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>24b. Were autopsy findings available prior to completion of cause of death?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>FOUND 8-23-96</b>		28b. Time of Injury <b>UNKNOWN</b> M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>FOUND IN HOUSE</b>		28d. Describe how injury occurred <b>UNKNOWN</b>				
		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>291 S. PULASKI HWY. BALTIMORE, MARYLAND</b>						
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 						
		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 24, 1996</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dennis J Chute</b>		<b>111 Penn Street, Baltimore, Maryland 21201</b>						
31. Data filed (Month, Day, Year) <b>AUG 29 1996</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

96 25669

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Mary J Dawidewicz</u>			2. Date of Death Month <u>August</u> Day <u>26th</u> Year <u>1996</u>			3. Time of Death <u>4:20 pm</u>								
	4e. Facility Name (If not institution, give street and number) <u>Harbor Hospital Center</u>			4b. City, Town, or Location of Death <u>Baltimore</u>			4c. County of Death <u>Baltimore</u>								
Funeral Director	5. Social Security Number <u>215-18-5279</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>73</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>OCT 10, 1922</u>		9. Birthplace (State or Foreign Country) <u>BALTIMORE</u>						
	Usual Residence of Decedent														
To Be Completed by Funeral Director	10e. State <u>MD</u>		10b. County <u>BALTIMORE</u>		10c. City, Town or Location <u>BALTIMORE</u>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	10e. Street and Number <u>2912 MICHIGAN AVENUE</u>				10f. Zip Code <u>21227</u>		10g. Citizen of What Country? <u>U.S.A.</u>								
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>WHITE</u>							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12+H</u> College (1-4or 5+) <u></u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>HOMEMAKER</u>			16b. Kind of Business/Industry <u>HOMEMAKING</u>							
	17. Father's Name (First, Middle, Last) <u>WILLIAM M. REICHERT, SR.</u>					18. Mother's Name (First, Middle, Maiden Surname) <u>GEORANNA COVELL</u>									
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <u>KATHLEEN A. MILLER(DAUGHTER)</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>528 CHALET WEST - MILLERSVILLE, MD 21108</u>										
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <u>LOUDON PARK CEMETERY</u>		Date <u>8/30/96</u>		20c. Location - City or Town, State <u>BALTIMORE</u>						
	21. Signature of Funeral Service Licensee <u>Jackie D. Shannon</u>				22. Name and Address of Facility <u>HUBBARD FUNERAL HOME INC.</u> <u>4107 WILKENS AVENUE-BALTIMORE, MD 21229</u>										
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.														
	<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a. <u>Respiratory failure</u> Due to (or as a consequence of):</td> <td rowspan="4">           Approximate Interval Between Onset and Death   <u>6 month</u>   <u>10 years</u> </td> </tr> <tr> <td>b. <u>Chronic Obstructive Lung Disease</u> Due to (or as a consequence of):</td> </tr> <tr> <td>c. <u></u> Due to (or as a consequence of):</td> </tr> <tr> <td>d. <u></u> Due to (or as a consequence of):</td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <u>Respiratory failure</u> Due to (or as a consequence of):	Approximate Interval Between Onset and Death  <u>6 month</u>  <u>10 years</u>	b. <u>Chronic Obstructive Lung Disease</u> Due to (or as a consequence of):	c. <u></u> Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <u>Respiratory failure</u> Due to (or as a consequence of):	Approximate Interval Between Onset and Death  <u>6 month</u>  <u>10 years</u>													
	b. <u>Chronic Obstructive Lung Disease</u> Due to (or as a consequence of):														
	c. <u></u> Due to (or as a consequence of):														
	d. <u></u> Due to (or as a consequence of):														
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Rheumatic heart disease</u> <u>s/p mitral valve replacement</u>								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)													
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <u>Chang Jian Chen, MD</u>		29c. License number <u>AS 2441614</u>		29d. Date signed (Month, Day, Year) <u>August 26th, 1996</u>									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Chang Jian Chen, 7888 American Circle #101, Glen Burnie, MD 21060</u>															
31. Date filed (Month, Day, Year) <u>AUG 29 1996</u>		32. Registrar's Signature <u>Winston R. [Signature]</u>													

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

item #5, filmg 739, 9/13/96, yw, per in  
 State of Maryland / Department of Health and Mental Hygiene  
 Certificate of Death

96 25670

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Gladys Agnes DEAN

2. Date of Death

Month Aug. 25, 1996 Year

3. Time of Death

1:45 PM

4a. Facility Name (If not institution, give street and number)

St. Elizabeth Nursing Home

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

212-01-1161

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 12, 1901

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1031 Maiden Choice Lane

10f. Zip Code

21227

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Dental Assistant

16b. Kind of Business/Industry

Dentistry

17. Father's Name (First, Middle, Last)

Homer W. CHARLES

18. Mother's Name (First, Middle, Maiden Surname)

Mamie BROOKS

19a. Informant's Name/Relationship (Type, Print)

SHARON ATKINSON (GREAT-NIECE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

108 MOUNTAIN ROAD - GLEN BURNIE, MD. 21061

20a. Method of Disposition

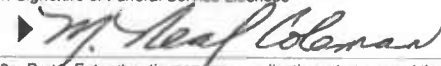
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Loudon Park Cemetery

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Hubbard Funeral Home, Inc.  
4107 Wilkens Avenue Baltimore, MD 2122923a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. *Chronic Progressive Dementia of Alzheimer type*  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier



29c. License number

DO 1786

29d. Date signed (Month, Day, Year)

August 26, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DR. LAURENCE R. GALLAGHER - 3455 WILKENS AVENUE - SUITE 300 - BALTIMORE, MD 21229

31. Date filed (Month, Day, Year)

SEP 13 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
 Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
 any injury or other traumatic event, the Medical Examiner must be notified at  
 once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
 within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and  
 completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25671

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Hazel Doris DeBoy

2. Date of Death

Month

Day

Year

August

27, 1996

3. Time of Death

8:23 AM

4a. Facility Name (If not institution, give street and number)

400 Old Orchard Rd.

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

212-34-9562

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

01/23/1907

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

MD.

10b. County

Baltimore

10c. City, Town or Location

Halethorp

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5717 Mineral Ave.

10f. Zip Code

21227

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

+2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Library

Balto. Co. Public

17. Father's Name (First, Middle, Last)

James Winslow

18. Mother's Name (First, Middle, Maiden Surname)

Orena Vaillette

19a. Informant's Name/Relationship (Type, Print)

Kathleen Whitaker/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16010 Falls Rd. Sparks, MD. 21152

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Mem. Park

Date

8/30/96

20c. Location - City or Town, State

Baltimore, MD.

21. Signature of Funeral Service Licensee

Phyllis Stach

22. Name and Address of Facility

Sterling Ashton Funeral Home, Inc.

736 Edmondson Ave. Balto., MD. 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Severe dementia*

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Scarlet fever

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

DOMESTIC RESIDENCE

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicida 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Damian E. Birchess MD

29c. License number

D 22114

29d. Date signed (Month, Day, Year)

August 28, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAMIAN E. BIRCHESS MD 5711 OLD

FREDERICK ROAD SUITE 18 BALTIMORE, MARYLAND 21229

31. Date filed (Month, Day, Year)

AUG 29 1996

32. Registrar's Signature

James Davidson

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



96 25672

DMMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25673

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARGARET M. EDMONDS

2. Date of Death

Month  
AUGUST

Day

22, 1996

3. Time of Death

7:29 P.M.

4a. Facility Name (If not institution, give street and number)

944 FERN TRAIL

4b. City, Town, or Location of Death

CROWNSVILLE

4c. County of Death

ANNE ARUNDEL

Funeral  
Director

5. Social Security Number

216-05-3487

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

103

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
DEC 20, 1892

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MD

10b. County

ANNE ARUNDEL

10c. City, Town or Location

CROWNSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

944 FERN TRAIL

10f. Zip Code

21032

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
8TH GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOMEMAKING

17. Father's Name (First, Middle, Last)

JOSEPH M. BUERLEN

18. Mother's Name (First, Middle, Maiden Surname)

ROSA NOLL

19a. Informant's Name/Relationship (Type, Print)

JOSEPH L. EDMONDS (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

944 FERN TRAIL - CROWNSVILLE, MARYLAND 21032

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

LOUDON PARK CEMETERY

Date

8/26/97

20c. Location - City or Town, State

BALTIMORE

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HUBBARD FUNERAL HOME INC.

4107 WILKENS AVENUE-BALTIMORE, MD 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a.

Natural

Due to (or as a consequence of):

b.

ASHD

Due to (or as a consequence of):

c.

Hypertension

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28e. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D17961

29d. Date signed (Month, Day, Year)

8/23/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. OSCAR FARIAS - 1667 CROFTON CENTER - SUITE 1 - CROFTON, MARYLAND 21114

31. Date filed (Month, Day, Year)

AUG 29 1996

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25674

Film G738 item 4,8,10b,10e,17 8-29-96 rja 1/2er FH

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Helen G. FREY

2. Date of Death  
Month Day Year

8-22-96

3. Time of Death

2335

4a. Facility Name (If not institution, give street and number)

RA COWLEY SHOCK TRAUMA

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

220 221709

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

6-8-02

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md

10b. County

Baltimore

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8109 Valley Lane  
8209 Valley Ln.

10f. Zip Code

21043

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Leidigs Bakery

17. Father's Name (First, Middle, Last)

Frank A. Fisher Francis A. Fisher

18. Mother's Name (First, Middle, Maiden Surname)

Mary M. Miller

19a. Informant's Name/Relationship (Type, Print)

Elizabeth Gallant

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

120 Oakdale Avenue Catonsville, Maryland 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

St. Mary's Cemetery

Date

8-26-96

20c. Location - City or Town, State

Ilchester, Maryland

21. Signature of Funeral Service Licensee

Acker Smith

M00544

22. Name and Address of Facility

Slack Funeral Home, P.A.  
Ellicott City, Md. 2104323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. INTRAVENTRICULAR HEMORRHAGE

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☒ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)

unk

28b. Time of  
Injury

unk M

28c. Injury at  
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Sheet fell out of bed

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

HOME

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

8109 Valley Lane 21043

29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

H. H. H.

29c. License number

D43055

29d. Date signed (Month, Day, Year)

8/22/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

NADER HARASHI 22 SOUTH GREENE ST Baltimore Md 21201

31. Date filed (Month, Day, Year)

AUG 29 1996

32. Registrar's Signature  
John Davidson

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25675

Film G738 item 1 Per FH 8-29-96 rja

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Ladris Lee Flowers</u>		2. Date of Death Month <u>8</u> Day <u>24</u> Year <u>96</u>		3. Time of Death <u>13:55p</u>
	4a. Facility Name (If not institution, give street and number) <u>md. House of Correction</u>		4b. City, Town, or Location of Death <u>Jessup, Md.</u>		4c. County of Death <u>AA</u>
Funeral Director	5. Social Security Number <u>217-68-0029</u>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>37</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.
	8. Date of Birth <u>JUN. 22, 1959</u>		9. Birthplace (State or Foreign Country) <u>BALTIMORE CITY,</u>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10c. City, Town or Location		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10a. State <u>MD</u>	10b. County <u>n/a</u>	<u>BALTIMORE</u>		
	10e. Street and Number <u>740 E. 37 th STREET</u>		10f. Zip Code <u>21218</u>		10g. Citizen of What Country? <u>UNITED STATES</u>
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <u>BLACK</u>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>11 th</u> College (1-4or 5+) <u>-</u>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>LABORER</u>		16b. Kind of Business/Industry <u>various trades</u>		
	17. Father's Name (First, Middle, Last) <u>HENRY LEE FLOWERS</u>		18. Mother's Name (First, Middle, Maiden Surname) <u>RUGIE MAE BUMPASS- FLOWERS</u>		
	19a. Informant's Name/Relationship (Type, Print) <u>HENRY LEE FLOWERS</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>740 E. 37 th STREET, BALTIMORE, MD 21218</u>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>CEDAR HILL CEMETERY</u>		20c. Location - City or Town, State <u>8-28 ANNE A RUNDEL CO, MD</u>
	21. Signature of Funeral Service Licensee <u>[Signature]</u>		22. Name and Address of Facility <u>WM. C. MARCHFH.-1101 E. NORTH AVENUE</u>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) <u>Fungal Sepsis</u>				
	Due to (or as a consequence of): <u>Acquired Immunodeficiency Syndrome</u>				
	Due to (or as a consequence of): <u>End Stage Renal disease - dialysis dependent</u>				
To Be Completed by Physician/Medical Examiner	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <u>INFIRMARY</u>
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>
			28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier <u>[Signature]</u>		29c. License number <u>D42806</u>		29d. Date signed (Month, Day, Year) <u>8/24/96</u>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>ASRESAHEGN GETACHEW</u> <u>P.O. Box 534</u> <u>Jessup, Md. 20794</u>				
State Registrar	31. Date filed (Month, Day, Year) <u>AUG 29 1996</u>		32. Registrar's Signature <u>[Signature]</u>		

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State of Maryland / Department of Health and Mental Hygiene

96 25676

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>John Robert Fox</b>				2. Date of Death Month <b>August</b> Day <b>26</b> Year <b>1996</b>				3. Time of Death <b>12:00 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>12021 Misty Rise Court</b>				4b. City, Town, or Location of Death <b>Clarksville</b>				4c. County of Death <b>Howard</b>	
Funeral Director	5. Social Security Number <b>090-48-4822</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>72</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 29 1924</b>		9. Birthplace (State or Foreign Country) <b>China</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>New York</b>		10b. County <b>Queens</b>		10c. City, Town or Location <b>Corona</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>49-22 97th Street</b>				10f. Zip Code <b>11368</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Chinese</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3 +</b>		18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Alternative Hair Designs</b>				16b. Kind of Business/Industry <b>Hair Retailer</b>			
	17. Father's Name (First, Middle, Last) <b>Bo Wan Fox</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Chin Yen Shen</b>					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Raymond Fox - Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12021 Misty Rise Ct. Clarksville, Md. 21029</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Columbia Memorial Park</b>		Date <b>8-29-96</b>		20c. Location - City or Town, State <b>Clarksville, Maryland</b>			
	21. Signature of Funeral Service Licensee <b>Allen Smith</b> M00544				22. Name and Address of Facility <b>Slack Funeral Home, P.A. Ellicott City, Md. 21043</b>					
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>metastatic lung cancer</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>1 year</b> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
Medical Certification: To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <b>Dr. King</b>					29c. License number <b>241139</b>			29d. Date signed (Month, Day, Year) <b>8/27/96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>11065 Little Patuxent Parkway, Columbia, Md. 21044</b>										
31. Date filed (Month, Day, Year) <b>AUG 29 1996</b>										
32. Registrar's Signature <b>Jana Davidson-Randall</b>										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



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State of Maryland / Department of Health and Mental Hygiene

96 25677

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROSALIE FARLEY</b>				2. Date of Death Month <b>August</b> Day <b>27</b> Year <b>1996</b>		3. Time of Death <b>8:35A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>St. Agnes Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>215-10-3092</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>84</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>08/07/1912</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>MD.</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Catonsville</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>26 North Belle Grove</b>		10f. Zip Code <b>21228</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>			
	17. Father's Name (First, Middle, Last) <b>Authur Pielert</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Gertrude Phelps</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Elmer Pielert/Nephew</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21042 3494 North Chatham Rd. Ellicott City, MD.</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory</b>		20c. Location - City or Town, State <b>8/29 Beltsville, MD.</b>			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Sterling Ashton Funeral Home, Inc. 736 Edmondson Ave. Balto., MD. 21228</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>BRONCHOPNEUMONIA</b> Due to (or as a consequence of): <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Bladder Cancer with Obstructive Uropathy</b> <b>Coronary Atherosclerosis</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>August 27, 1996</b>		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier  <b>MD.</b>		29c. License number <b>D47380</b>	
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) <b>August 27, 1996</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. David P. Frishberg St. Agnes Hospital 900 Caton Avenue Baltimore, MD 21229</b>		31. Date filed (Month, Day, Year) <b>AUG 29 1996</b>		32. Registrar's Signature 	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

96 25678

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIE GILMORE				2. Date of Death Month Day Year August 25 96		3. Time of Death 2:00 PM	
	4a. Facility Name (If not institution, give street and number) MARYLAND GENERAL HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE CITY	
Funeral Director	5. Social Security Number 218-42-9993		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) MAY 2, 1920	9. Birthplace (State or Foreign Country) ELLOREE, SC
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD		10b. County n/a		10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 2423 FRANCES STREET				10f. Zip Code 21217		10g. Citizen of What Country? UNITED STATES	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER		16b. Kind of Business/Industry DISABLED			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) HYDRICK GILMORE				18. Mother's Name (First, Middle, Maiden Surname) ROBBIENELL DAVIS			
	19a. Informant's Name/Relationship (Type, Print) SHIRLEY HUDSON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2423 FRANCES ST., BALTIMORE, MD 21217			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) WESTERN STAR CEMETERY		Date 8-31		20c. Location - City or Town, State CATONSVILLE, MD	
	21. Signature of Funeral Service Licensee Shirley B. Harris				22. Name and Address of Facility WM. C. MARCH FH. - 1101 E. NORTH AVENUE			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ASPIRATION PNEUMONIA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death MINUTES
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE PULMONARY DISEASE							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier Surjit S. Julka MD				29c. License number D26 395		29d. Date signed (Month, Day, Year) 8/25/96	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) SURJIT S. JULKA MD 821 N. EUTAW ST BALTIMORE MD 21201							
31. Date filed (Month, Day, Year) AUG 29 1996				32. Registrar's Signature Hudson-Rendell				



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State of Maryland / Department of Health and Mental Hygiene

96 25679

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>KEITH GRIFFIN JR.</b>				2. Date of Death Month Day Year <b>AUG. 27, 1996</b>				3. Time of Death <b>1410 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>HOPKINS/BAYVIEW HOSPITAL I.C.U</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death <b>BALTO, CITY</b>	
Funeral Director	5. Social Security Number <b>214-94-5624</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>16</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>NOV. 7, 1979</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>4719 ELISON AVENUE</b>				10f. Zip Code <b>21206</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9TH</b> College (1-4 or 5+) <b>N/A</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>STUDENT</b>			16b. Kind of Business/Industry <b>HIGH SCHOOL</b>		
	17. Father's Name (First, Middle, Last) <b>KEITH GRIFFIN, SR.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ANGELA BOYD</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>RALPH HOLMES - STEP FATHER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4719 ELISON AVENUE BALTO, MD. 21206</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT. ZION CEMETERY</b>		Date <b>AUG. 31, 1996</b>		20c. Location - City or Town, State <b>BALTO, MD.</b>			
	21. Signature of Funeral Service Licensee <i>Calvin B. Scruggs</i>				22. Name and Address of Facility <b>CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <i>Gunshot Wound of the Head</i> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <b>8/26/96</b>		28b. Time of Injury <b>2:30 PM</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Subject shot</b>		
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Street</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>4700 610th Elison Avenue, Baltimore Maryland</b>								
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <i>Theodore M. King</i>				29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>AUG. 28, 1996</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201</b>										
31. Date filed (Month, Day, Year) <b>AUG 29 1996</b>										
32. Registrar's Signature <i>John Davidson-Randall</i>										

Baltimore, Maryland 21215-0020

Form 10-1 (Rev. 1-95) Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25680

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Laura E HARDY</b>				2. Date of Death Month <b>August</b> Day <b>27</b> , 1996 Year		3. Time of Death <b>11:20p.m.</b>		
	4a. Facility Name (If not institution, give street and number) <b>Franklin Square Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>224-40-0161</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>71</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>March 30, 1925</b>		
	9. Birthplace (State or Foreign Country) <b>Virginia</b>		10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>331 E. Lorraine</b>		10f. Zip Code <b>21218</b>		10g. Citizen of What Country? <b>U.S.A</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify <b>Black</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>N/A</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Domestic</b>		16b. Kind of Business/Industry <b>House Keeping</b>		17. Father's Name (First, Middle, Last) <b>Unknown</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Laura Alice Oliver</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Preston Hardy</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>60 King Charles Circle, Baltimore County 21237</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Mem. Park</b>		20c. Location - City or Town, State <b>August 31, 1996 Baltimore, Maryland</b>	
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>Douglas Funeral Service 1701 Duncannon St., Baltimore, Md 21217</b>		23a. Cause of Death (Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.)  Immediate Cause (Final disease or condition resulting in death) <b>a. Sepsis with multi organ failure</b> Due to (or as a consequence of): <b>b. Bowel infarction</b> Due to (or as a consequence of): <b>c. Urosepsis</b> Due to (or as a consequence of): <b>d.</b>		Approximate Interval Between Onset and Death <b>30 hours</b> <b>30 hours</b> <b>30 hours</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Noninsulin dependent diabetes mellitus, meningioma, carcinoma of breast</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>045206</b>		29d. Date signed (Month, Day, Year) <b>8/27/96</b>			
30. Name and address of person who completed cause of death (item 23a) (Type, Print) <b>Dr. Thomas Kottarathil 9000 Franklin Square Drive Baltimore, Maryland 21237</b>		31. Date filed (Month, Day, Year) <b>AUG 29 1996</b>		32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25681

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Frances

Hartsock

2. Date of Death

August 24 1996

3. Time of Death

1:45 AM

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

none

5. Social Security Number

220-80-3912

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

58

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 21, 1938

9. Birthplace (State or Foreign Country)

unknown

Usual Residence of Decedent

10a. State

unknown

10b. County

unknown

10c. City, Town or Location

unknown

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

unknown

10f. Zip Code

unknown

10g. Citizen of What Country?

unknown

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

unknown

College (1-4 or 5+)

unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

unemployed

16b. Kind of Business/Industry

none

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

John Bothe/unknown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

unknown

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☒ Other (Specify) State rem.

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State of Maryland-Anatomy Board-655 W. Baltimore St.-Baltimore, Maryland 21201-1559

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Cardio pulmonary arrest

Due to (or as a consequence of):

b. Metastatic Pancreatic CA

Due to (or as a consequence of):

c. Sepsis

Due to (or as a consequence of):

d. Gastrointestinal bleeding

Approximate Interval Between Onset and Death

10 min

&gt; one year

2 days

&gt; one day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Emad A. Mikhail

29c. License number

AT 2438946

29d. Date signed (Month, Day, Year)

August 24/1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Emad A. Mikhail, Union Memorial Hosp., Balt. MD

31. Date filed (Month, Day, Year)

AUG 29 1996

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
item #28a,28f, filing 738, 8/30/96, cyw, per md.

## Certificate of Death

Reg. No.

96 25682

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLES LOUIS HEIL

2. Date of Death

Month Day Year  
AUGUST 21, 1996

3. Time of Death

4:48pm

4a. Facility Name (If not institution, give street and number)

INTERSECTION 695 &amp; ROUTE #2

4b. City, Town, or Location of Death

N/A

4c. County of Death

ANNE ARUNDEL

Funeral  
Director

5. Social Security Number

219-26-4673

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

56

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
FEB. 12, 1946

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6915 ALTER STREET

10f. Zip Code

21207

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

PARAMEDIC

16b. Kind of Business/Industry

BALTIMORE CITY FIRE DEPARTMENT

17. Father's Name (First, Middle, Last)

HERMAN JOHN HEIL

18. Mother's Name (First, Middle, Maiden Surname)

DORIS BERG

19a. Informant's Name/Relationship (Type, Print)

MRS. FRONA HEIL (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6915 ALTER ST. BALTIMORE, MD 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HEBREW YOUNG MENS -

Date

8-26-1996- BALTIMORE, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ellenore Levinson

22. Name and Address of Facility

Sol Levinson &amp; Bros., Inc.

8900 Reisterstown Road Pikesville, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☒ Other (Specify) Roadway

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☒ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

8-21-96

28b. Time of Injury

4-45PM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Driver Auto - Auto Collision

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ROADWAY

28f. Location (Street and Number or Rural Route Number, City or Town, State)

I-695

29a. Certifier (Check only one)

1 ☐ Certifying Physician2 ☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David R Fowler

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

Aug. 23, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David R Fowler

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 29 1996

32. Registrar's Signature

Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

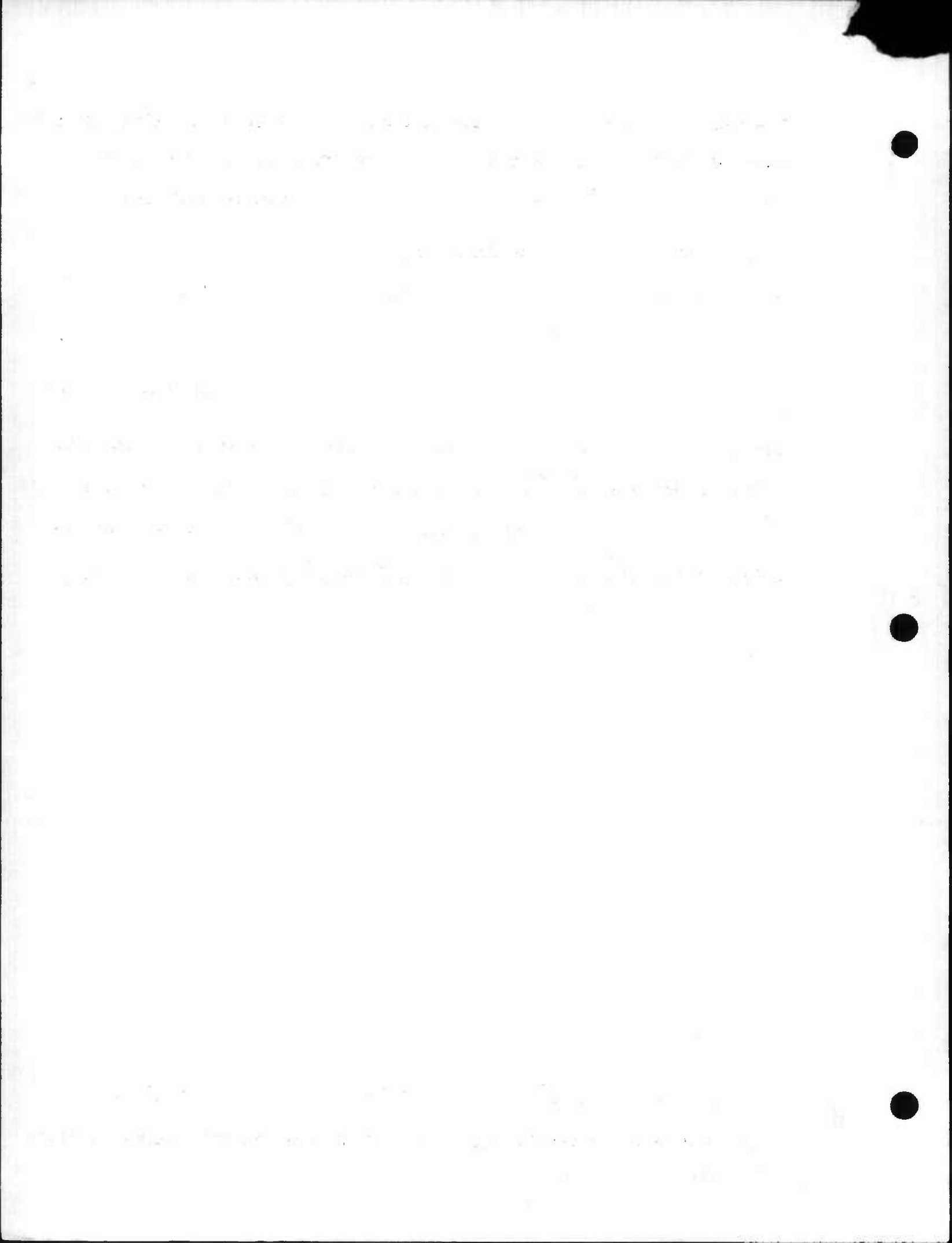
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25683

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FRANCES JOYCE HAMMERBACHER</b>				2. Date of Death Month Day Year <b>AUGUST 28, 1996</b>		3. Time of Death <b>12:55 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>SAINT JOSEPH MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>TOWSON, MARYLAND</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>214-24-8707</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>66</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug. 11, 1930</b>	
	9. Birthplace (State or Foreign Country) <b>New York</b>		10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore City</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <b>3915 Chesterfield Avenue</b>		10f. Zip Code <b>21213</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th Grade</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Sales</b>		17. Decedent's Kind of Business/Industry <b>Window Manufacturing Company</b>		18. Decedent's Name (First, Middle, Maiden Surname) <b>Harold Unknown Sollish Effie Unknown Schwartz</b>	
	19a. Informant's Name/Relationship (Type, Print) <b>Melvin Ross Hammerbacher, Sr. Husband:</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3915 Chesterfield Avenue, Baltimore, Maryland 21213</b>		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Oak Lawn Cemetery</b>	
To Be Completed by Physician/Medical Examiner	20c. Date <b>8/31/96</b>		20d. Location - City or Town, State <b>Baltimore, Maryland</b>		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206</b>	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>e. SEPSIS</b>		23b. Due to (or as a consequence of):  Approximate Interval Between Onset and Death <b>36 HOURS</b>		23c. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>f. KIDNEY FAILURE</b>		23d. Due to (or as a consequence of):  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>RESPIRATORY FAILURE</b>	
To Be Completed by Physician/Medical Examiner	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		23f. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		23g. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	25. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		26. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		27a. Date of Injury (Month, Day Year) <b>8/28/96</b>		27b. Time of Injury <b>M</b>	
To Be Completed by Physician/Medical Examiner	27c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		27d. Describe how Injury occurred		27e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		27f. Location (Street and Number or Rural Route Number, City or Town, State)	
	28a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28b. Signature and title of certifier 		28c. License number <b>D 46673</b>		28d. Date signed (Month, Day, Year) <b>8/28/96</b>	
To Be Completed by Physician/Medical Examiner	29. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ANTHONY HERBERT GUARINO, M.D., 7620 YORK ROAD TOWSON, MARYLAND 21204</b>		30. Date filed (Month, Day, Year) <b>AUG 29 1996</b>		31. Registrar's Signature 		32. Registrar's Name <b>John C. Miller, Inc.</b>	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25684

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>LUCILLE HOLLAND</b>				2. Date of Death Month <b>Aug</b> / Day <b>26</b> / Year <b>1996</b>		3. Time of Death <b>10 35 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>Church Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
5. Social Security Number <b>219-20-7892</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) <b>93</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>10/04/1902</b>	9. Birthplace (State or Foreign Country) <b>Georgia</b>
Usual Residence of Decedent							
10a. State <b>MD.</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Dundalk</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>2922 Liberty Parkway</b>				10f. Zip Code <b>21222</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>	
17. Father's Name (First, Middle, Last) <b>O.B. Whitehead</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Frances West</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Edwin Van Holland/Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21222</b> <b>2920 Liberty Parkway, Apt. D. Dundalk, MD.</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Baltimore National</b>		Date <b>8/30/96</b>		20c. Location - City or Town, State <b>Baltimore, MD.</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Bradley-Ashton Funeral Home, Inc.</b> <b>2134 Willow Spring Rd. Dundalk, MD. 21222</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. PNEUMONIA.</b> Due to (or as a consequence of):						Approximate Interval Between Onset and Death <b>DAYS</b>	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  <b>b.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ARTERIO SCLEROSIS</b> <b>DIABETES MELLITUS</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 		29c. License number <b>D17322</b>		29d. Date signed (Month, Day, Year) <b>Aug. 26, 1996</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>A.R. NAZEMI, M.D. CHURCH HOSPITAL, BACT. MD.</b>							
31. Date filed (Month, Day, Year) <b>AUG 29 1996</b>		32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

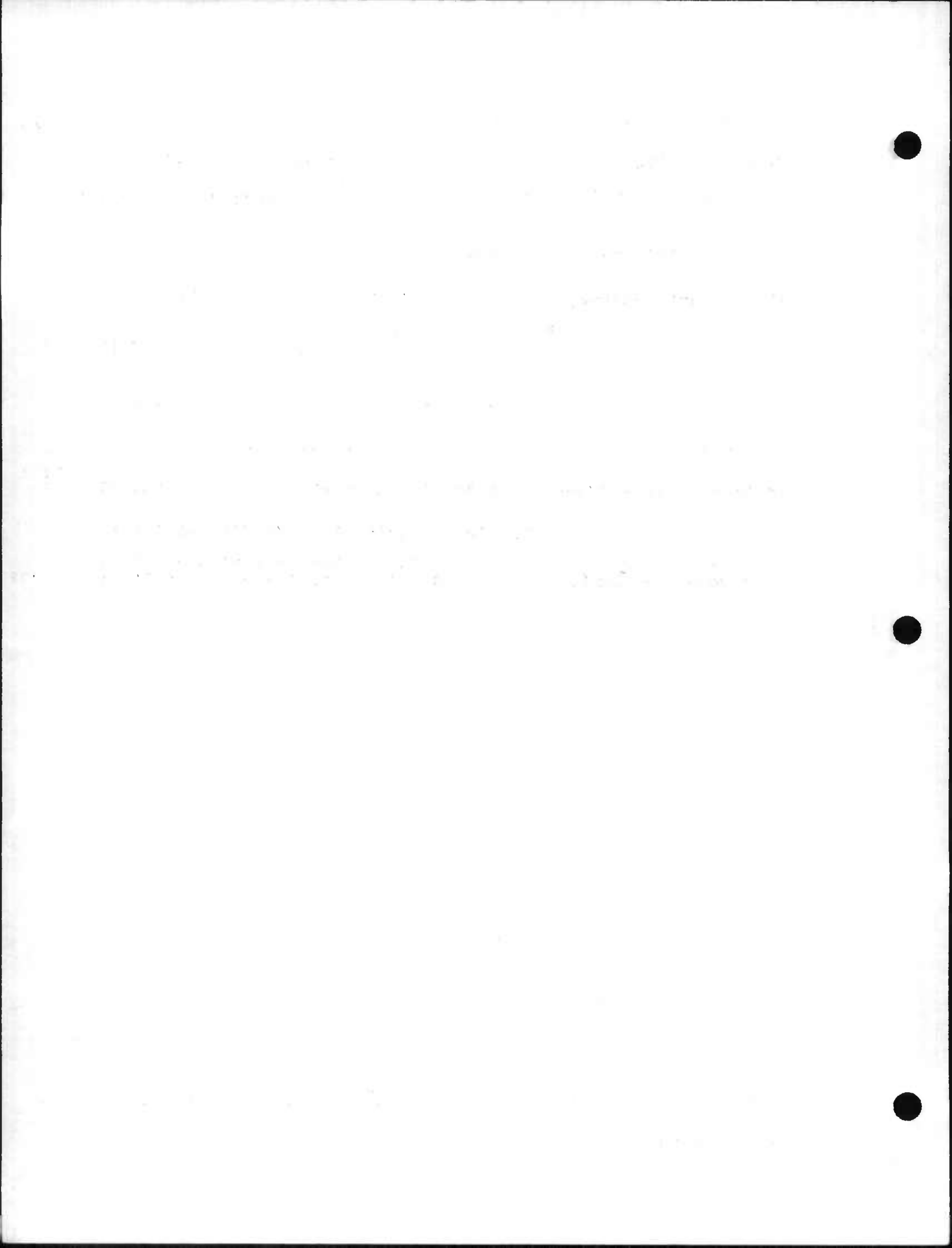
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Registrar for Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Film G738 item 2 per FH 8-29-96 rja

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25685

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James Thomas Harris

2. Date of Death

Month 8 Day 17 Year 96

3. Time of Death

11:20A

4a. Facility Name (If not institution, give street and number)

2725 Walbrook Ave Apt 409

4b. City, Town, or Location of Death

BALTO

4c. County of Death

N/A

5. Social Security Number

217-12-8198

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

AUG 7, 1922

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10e. State

MD

10b. County

N/A

10c. City, Town or Location

BALTO

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2725 WALBROOK AVE

10f. Zip Code

21216

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (14 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LABORER

16b. Kind of Business/Industry

SPARROWS POINT

17. Father's Name (First, Middle, Last)

UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname)

MIKE HARRIS

19a. Informant's Name/Relationship (Type, Print)

SANDRA FORD

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15 N. EDEN ST BALTO, MD 21231

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST VA

Date

AUG 23

20c. Location - City or Town, State

OWINGS MILLS, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

BETTS FUNERAL HOME

1129 N. CAROLINE ST BALTO, MD 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Myocardial infarction

Due to (or as a consequence of):

b.

Atherosclerotic disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

40

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

P09746

29d. Date signed (Month, Day, Year)

8/20/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Baltimore Veterans Hospital, 10 N. Green St, Baltimore, MD

31. Date filed (Month, Day, Year)

AUG 29 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





96 25686

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EVELYN REBECCA JOHNSON				2. DATE OF DEATH MONTH DAY YEAR AUGUST 26 1996		3. TIME OF DEATH 07:32 P M	
4. SOCIAL SECURITY NUMBER 220-07-5930		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH (Month, Day, Year) 08-14-1907	
8. BIRTHPLACE (State or Foreign Country) MARYLAND		9a. FACILITY NAME (If not institution, give street and number) WESLEYAN HEALTH CARE CENTER		9b. CITY, TOWN OR LOCATION OF DEATH DENTON		9c. COUNTY OF DEATH CAROLINE	
10a. STATE MARYLAND				10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION PASADENA	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 202 CHESTNUT STREET				10f. ZIP CODE 21122		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SELF EMPLOYED		15b. KIND OF BUSINESS/INDUSTRY MOTEL			
16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SELF EMPLOYED				16b. KIND OF BUSINESS/INDUSTRY MOTEL			
17. FATHER'S NAME (First, Middle, Last) CLARENCE L. WARFIELD				18. MOTHER'S NAME (First, Middle, Maiden Surname) LENORA STINCHCOMB			
19a. INFORMANT'S NAME (Type/Print) MR. ELWOOD R. JOHNSON (SON)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8197 DETOUR ROAD, DENTON, MARYLAND 21629			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GLEN HAVEN MEMORIAL PARK		DATE 8/30/96		20c. LOCATION — City or Town, State GLEN BURNIE, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>R. Hays Hopkins</i>				22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061			
23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>dehydration</u> DUE TO (OR AS A CONSEQUENCE OF) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. c. d. Approximate Interval Between Onset and Death <u>days</u>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>meningeoma</u> <u>poly myalgia rheumatica</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Wafik Zaki M.D.</i>				29c. LICENSE NUMBER D47534		29d. DATE SIGNED (Month, Day, Year) AUGUST 27, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) WAFIK ZAKI M.D. P.O. BOX 496 DENTON, MD 21629							
31. DATE FILED (Month, Day, Year) AUG 29 1996		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS, P.O. BOX 68760  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25687

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Wiley Lee Johnson</b>				2. Date of Death Month <b>August</b> Day <b>25</b> Year <b>1996</b>		3. Time of Death <b>11:21 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Mercy Hospital 301 St. Paul Place</b>				4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death	
Funeral Director	5. Social Security Number <b>239-42-6810</b>		6. Sex <b>1 M 2 F</b>		7. Age (In yrs. last birthday) <b>63</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 6, 1933</b>	
	9. Birthplace (State or Foreign Country) <b>Virginia</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore City</b>		10c. City, Town or Location <b>Baltimore City</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <b>1 X Yes 2 No</b>		10e. Street and Number <b>3934 Reisterstown Road</b>		10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>United States of America</b>	
	11. Marital Status <b>1 Never Married 2 X Married 3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 X No</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 X No Specify:</b>		14. Race - American Indian, Black, White, etc. <b>Specify: Black</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) College (1-4 or 5+)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cement Masonry</b>		16b. Kind of Business/Industry <b>Construction</b>		17. Father's Name (First, Middle, Last) <b>Lonnice Johnson</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>Ollie Brown</b>		19a. Informant's Name/Relationship (Type, Print) <b>Edith Johnson / Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3934 Reisterstown Road Baltimore, Maryland 21215</b>		20a. Method of Disposition <b>1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Western Star Cemetery</b>		20c. Date <b>8/30/96</b>		20d. Location - City or Town, State <b>Baltimore County, MD</b>		21. Signature of Funeral Service Licensee <b>Maggaban G. Henson</b>	
	22. Name and Address of Facility <b>Maggaban G. Henson Mortician c/o Chatman-Harris Funeral Home 5340-44 Reisterstown Road Baltimore, Maryland 21215</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Sepsis</b> Due to (or as a consequence of): <b>Lung Cancer</b> Due to (or as a consequence of): <b>Pneumonia</b> Due to (or as a consequence of):		Approximate Interval Between Onset and Death <b>17 days</b> <b>5 months</b> <b>17 days</b>		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <b>1 Yes 2 X No</b>		24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 X No</b>		25. Was case referred to medical examiner? <b>1 Yes 2 X No</b>		26. Place of Death (Check only one) Hospital: <b>1 X Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>	
	27. Manner of Death <b>1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1 Yes 2 No</b>	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <b>1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>		29b. Signature and title of certifier <b>Vijay Pethkar M.D.</b>	
	29c. License number <b>050853</b>		29d. Date signed (Month, Day, Year) <b>8/29/96</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Vijay Pethkar 301 St. Paul Place, Baltimore 21208</b>		31. Date filed (Month, Day, Year) <b>AUG 29 1996</b>	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

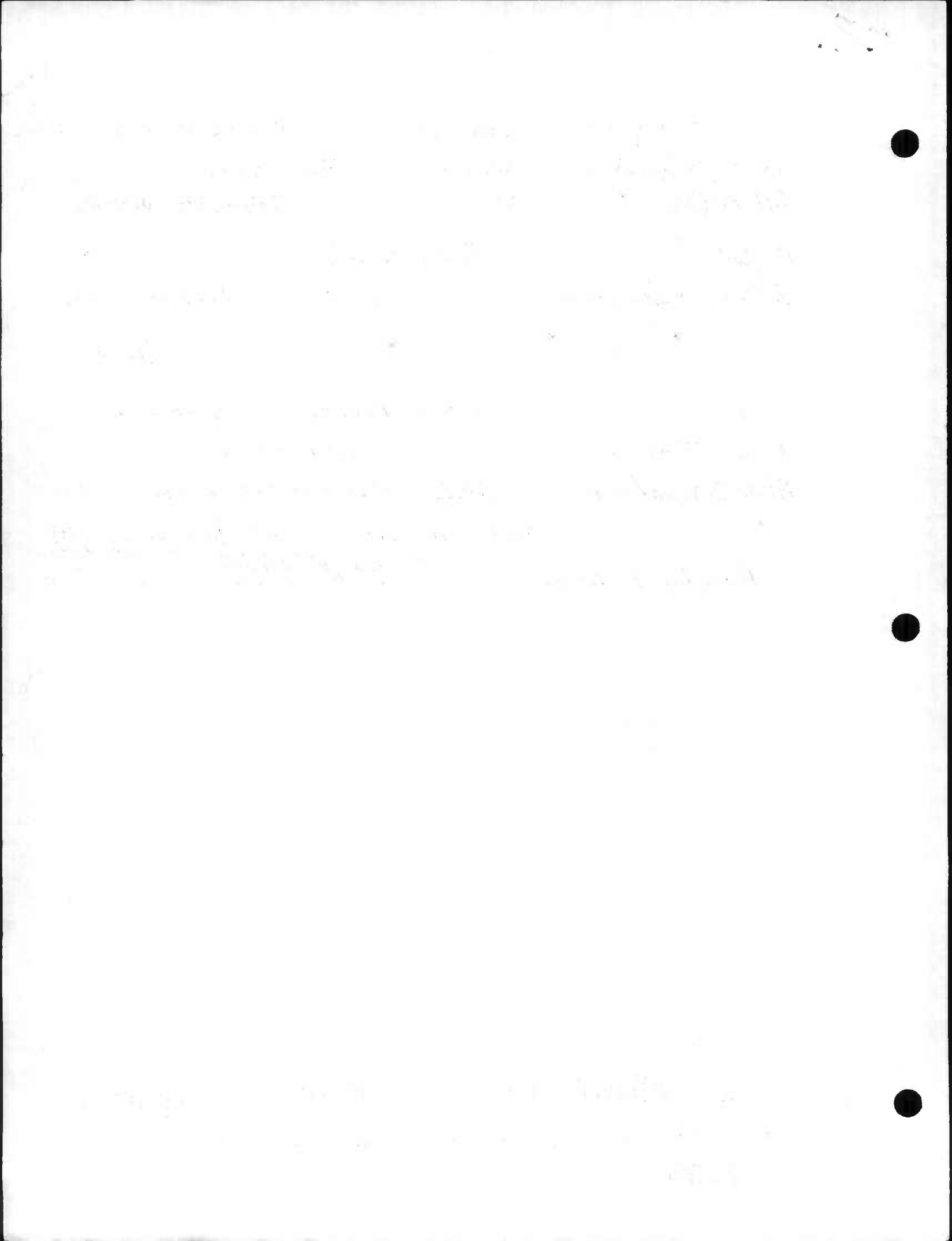
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25688

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOSEPH KERR</b>				2. Date of Death Month Day Year <b>AUGUST 21 1996</b>		3. Time of Death <b>5:35 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>GREATER BALTIMORE MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>217-18-2908</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>75</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>March 19, 1921</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Phoenix</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>14409 Manor Road</b>				10f. Zip Code <b>21131</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates <b>8-4-42 to 1-16-46</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Automobile Salesman</b>		16b. Kind of Business/Industry <b>Automotive</b>		
17. Father's Name (First, Middle, Last) <b>George Edward Kerr</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Theresa Loretta Corbitt</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Dorothy Kerr/Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14409 Manor Road-Phoenix, Maryland 21131</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		Data		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Director</b>				22. Name and Address of Facility <b>State Anatomy Board-655 W. Baltimore Street Baltimore, Maryland 21201-1559</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Chronic pulmonary fibrosis</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								Approximate Interval Between Onset and Death <b>57 years</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>S. H. Wilson MD</b>		29c. License number <b>D12487</b>		29d. Date signed (Month, Day, Year) <b>8.22.96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								
31. Date filed (Month, Day, Year) <b>AUG 29 1996</b>		32. Registrar's Signature <b>William R. Pendall</b>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25689

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph KALASAUSKY

2. Date of Death

Month Day Year  
August 25, 1996

3. Time of Death

12:24 pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital

4b. City, Town, or Location of Death

Rossville

4c. County of Death

Baltimore County

5. Social Security Number

172-18-9313

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 12, 1920

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Edgemere

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2305 Sparrows Point Road

10f. Zip Code

21219

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

9 Years

18a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Transportation

17. Father's Name (First, Middle, Last)

Peter Kalasausky

18. Mother's Name (First, Middle, Maiden Surname)

Mary Good

19a. Informant's Name/Relationship (Type, Print)

Rose Marie Kalasausky/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2305 Sparrows Point Road Edgemere, Maryland 21219

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Holly Hill Mem. Gdns. 8/29/96

Date

20c. Location - City or Town, State

Middle River, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.  
7922 Wise Ave. Dundalk, Maryland 2122223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

Ischemic Enteritis

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to Immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of causa  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 8 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D22481

29d. Date signed (Month, Day, Year)

August 26, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George Jabaji M.D. 9000 Franklin Square Drive, Baltimore, Maryland 21237

31. Date filed (Month, Day, Year)

AUG 29 1996

32. Registrar's Signature

Julia Davidson-Randall

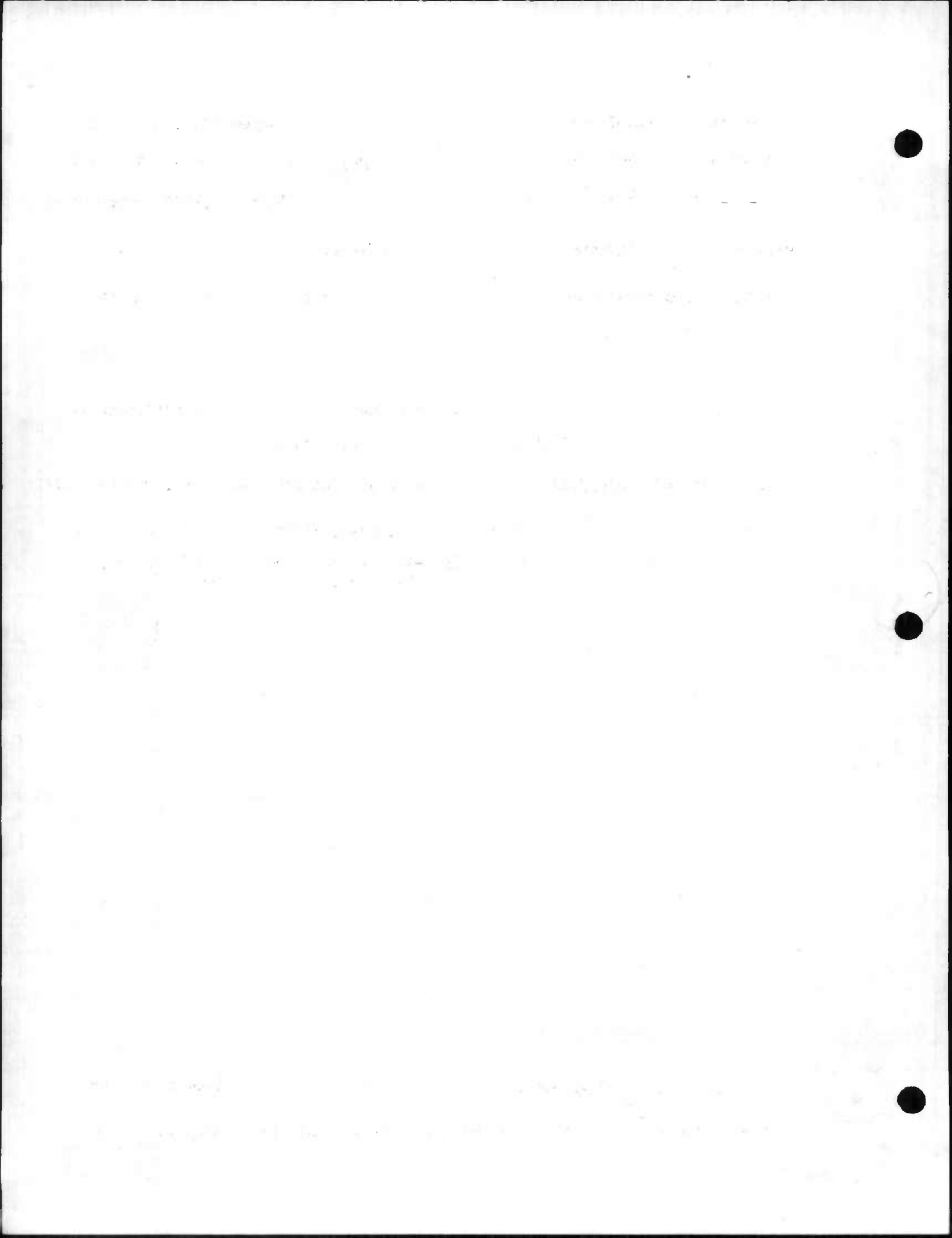
State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerDivision of Vital Records, P.O. Box 68760,  
to the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25690

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BRIETA

KESSLER

2. Date of Death  
Month Day Year

AUGUST 26 1996

3. Time of Death

11:30 AM

4a. Facility Name (If not institution, give street and number)

GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

n/a

Funeral  
Director

5. Social Security Number

218-36-2071

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

57 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

NOV. 28, 1938

9. Birthplace (State or Foreign Country)

NORTH CAROLINA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

OWINGS MILLS

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8009-B TOWNSHIP DRIVE

10f. Zip Code

21117

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

PURCHASING DIRECTOR

16b. Kind of Business/Industry

CATERING

17. Father's Name (First, Middle, Last)

LEON

POLAKAVETZ

18. Mother's Name (First, Middle, Maiden Surname)

SHIRLEY

MACKS

19a. Informant's Name/Relationship (Type, Print)

SHERYL PREISS (DAUG.)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9 ASTON COURT OWINGS MILLS, MD 21117

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

HEBREW FRIENDSHIP

Data

8-28-1996- BALTIMORE, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Michael Kruger

22. Name and Address of Facility

Sol Levinson &amp; Bros., Inc.

8900 Reisterstown Road Pikesville, MD 21208

23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

ASYSTOLE

Due to (or as a consequence of):

HYPERKALEMIA

Due to (or as a consequence of):

RENAL FAILURE

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

30 mins.

1 WEEK

3 WEEKS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC LYMPHOCYTIC LEUKEMIA

SEPSIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29e. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Johanna Boalens MD RESIDENT

29c. License number

D47861

29d. Date signed (Month, Day, Year)

AUGUST 26 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOSEPH AKWASI BOATENG GOOD SAMARITAN HOSP. BALTIMORE MD 21239

31. Date filed (Month, Day, Year)

AUG 29 1996

32. Registrar's Signature

Gina Davidson-Randall

State  
Registrar

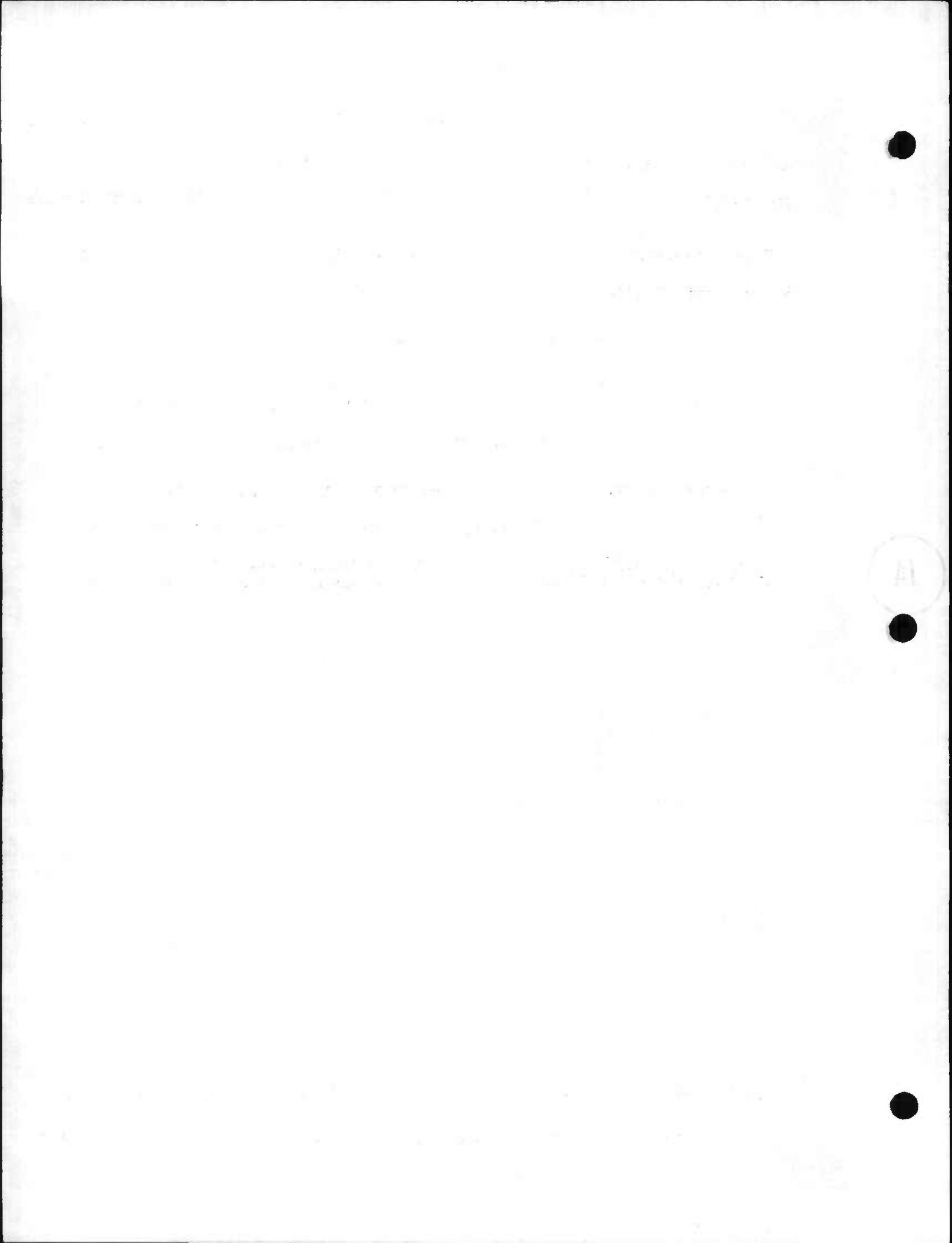
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detected for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

17

State of Maryland / Department of Health and Mental Hygiene

96 25691

Film G738 item 1 per Dr. 8-29-96 rja

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Michael William Kohlstrom, Phd.</b> <b>WILLIAM KOHLSTROM</b>				2. Date of Death Month <b>August</b> Day <b>24</b> Year <b>1996</b>		3. Time of Death <b>505A</b>	
	4a. Facility Name (If not institution, give street and number) <b>Stella Maris Hospice</b>				4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>174-36-5853</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>48</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Dec. 29, 1947</b>	9. Birthplace (State or Foreign Country) <b>Pa.</b>
	Usual Residence of Decedent							
10a. State <b>Md.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>5620 Pimlico Rd.</b>				10f. Zip Code <b>21209</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Consultant</b>		16b. Kind of Business/Industry <b>Computer</b>		
17. Father's Name (First, Middle, Last) <b>Albert L. Kohlstrom</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary A. Lanasa</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Mary A. Kohlstrom/Mother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>PO Box 2305 York, Pa. 17405</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hilltop Service Corp.</b>		Date <b>8/27/96</b>		20c. Location - City or Town, State <b>Towson, Md.</b>
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Cytomegalovirus Encephalitis</b> Due to (or as a consequence of): <b>b. Acquired Immunodeficiency Syndrome</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  c. Due to (or as a consequence of):  d.								Approximate Interval Between Onset and Death <b>unknown</b> <b>4 years, Approx</b> <b>-8 years</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b>				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28e. Date of injury (Month, Day, Year)		28b. Time of injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 		29c. License number <b>1705509</b>		29d. Date signed (Month, Day, Year) <b>8 26 96</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. EDDIE NAKHUDA 2300 DULANEY VALLEY RD., TOWSON, MD 21204</b>								
31. Date filed (Month, Day, Year) <b>AUG 29 1996</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Reg. No.



Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

1. Decedent's Name (First, Middle, Last)  
Rita-C. Kwasnik

2. Date of Death  
Month August Day 24 Year 1996

3. Time of Death  
7:50 PM

4a. Facility Name (If not institution, give street and number)  
Gilcrest Hospice Center

4b. City, Town, or Location of Death  
Towson

4c. County of Death  
Baltimore

5. Social Security Number  
215-09-8176

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)  
77 Yrs.

8. Date of Birth (Month, Day, Year)  
9-26-1918

9. Birthplace (State or Foreign Country)  
Maryland

10a. State  
Maryland

10b. County  
Baltimore

10c. City, Town or Location  
Towson

10d. Inside City Limits  
1 ☐ Yes 2 ☒ No

10e. Street and Number  
204 E. Joppa Road, Apt. 1202

10f. Zip Code  
21286

10g. Citizen of What Country?  
U. S. A.

11. Marital Status  
1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.  
Specify: White

15. Decedent's Education (Specify only highest grade completed)  
Elementary/Secondary (0-12) College (1-4 or 5+)  
1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  
Homemaker

16b. Kind of Business/Industry  
Own Home

17. Father's Name (First, Middle, Last)  
Uriah Jones

18. Mother's Name (First, Middle, Maiden Surname)  
Catherine Wernig

19a. Informant's Name/Relationship (Type, Print)  
R. Manfred Kwasnik (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
204 E. Joppa Road, Apt. 1202 Towson, Maryland 21286

20a. Method of Disposition  
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)  
Hilltop Service Corp.

20c. Location - City or Town, State  
Towson, Maryland

21. Signature of Funeral Service Licensee  
Wallace S. Brooks, Jr.

22. Name and Address of Facility  
Ruck Towson Funeral Home, Inc.  
1050 York Road, Towson, Md. 21204

23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
Immediate Cause (Final disease or condition resulting in death)  
metastatic lung cancer  
Due to (or as a consequence of):  
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  
H/O Cancer of stomach  
emphysema

23b. Did tobacco use contribute to the cause of death?  
1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)  
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death  
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)  
NA

28b. Time of Injury  
M

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)  
1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier  
W.A. Riley, M.D.

29c. License number  
025205

29d. Date signed (Month, Day, Year)  
8/25/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)  
W.A. Riley, M.D. 6701 N. Charles St. Balto, md 21204

31. Date filed (Month, Day, Year)  
AUG 27 1996

32. Registrar's Signature  
Julie Taylor-Randall





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25694

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>RICHARD J LEWISON</b>				2. Date of Death Month Day Year <b>AUGUST 21, 1996</b>		3. Time of Death <b>3:25 PM</b>	
	4a. Facility Name (If not Institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>220-44-4449</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>43</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 28, 1953</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>4100 N. Charles St. Apt. 501</b>		10f. Zip Code <b>21218</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life) <b>Officer</b>		16b. Kind of Business/Industry <b>Commercial Airlines</b>			
	17. Father's Name (First, Middle, Last) <b>Edward Frederick Lewison</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Betty Fleischmann</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Dr. Edward Frederick Lewison Father</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4100 N. Charles St. Apt. 501 Baltimore, MD 21218</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc. 08/22/96</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>			
	21. Signature of Funeral Service <b>Dawn F. McDonald</b>				22. Name and Address of Facility <b>Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228</b>			
	23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Physician /Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <b>[Signature]</b>				29c. License number <b>N2488</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 21, 1996</b>	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>FRED CHAN 600 NORTH WOLFE STREET BALTIMORE MARYLAND 21287-8106</b>							
	31. Date filed (Month, Day, Year) <b>AUG 29 1996</b>							
	32. Registrar's Signature <b>[Signature]</b>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Film G738 item 26 per DR 8-29-96 rja

## Certificate of Death

Reg. No.

96 25695

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Gladys Virginia Lazzara</b>		2. Date of Death Month Day Year <b>August 26, 1996</b>		3. Time of Death <b>6:00pm</b>	
4a. Facility Name (If not institution, give street and number) <b>104 Judywood Lane</b>			4b. City, Town, or Location of Death <b>Essex</b>		4c. County of Death <b>Baltimore</b>
5. Social Security Number <b>212-34-7380</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>61</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 23, 1935</b>
9. Birthplace (State or Foreign Country) <b>Maryland</b>					
Usual Residence of Decedent					
10a. State <b>Md.</b>	10b. County <b>Baltimore</b>	10c. City, Town or Location <b>Essex</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number <b>104 Judywood Lane</b>		10f. Zip Code <b>21221</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> Collage (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Supervisor</b>		16b. Kind of Business/Industry <b>Electronics</b>	
17. Father's Name (First, Middle, Last) <b>John Snyder</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Gladys S. Harris</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Robert Lazzara</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>104 Judywood Lane Baltimore Md. 21221</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Moreland Memorial</b>		20c. Location - City or Town, State <b>Baltimore Md.</b>	
21. Signature of Funeral Service Licensee <b>R. Terry Connelly</b>		22. Name and Address of Facility <b>Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>COLON CARCINOMA WITH METASTASIS</b> Due to (or as a consequence of): <b>ANAEMIA</b> Due to (or as a consequence of): <b>RENAL INSUFFICIENCY</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <b>R. Terry Connelly</b>		29c. License number <b>D 31464</b>		29d. Date signed (Month, Day, Year) <b>8/27/96</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SHOBIB A. HASHEMI 821 N. EUTAW ST SUITE 308 BALTIMORE MD 21201</b>					
31. Date filed (Month, Day, Year) <b>AUG 29 1996</b>		32. Registrar's Signature <b>W. Davidson-Randall</b>			

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 25696

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN DWIGHT LANG				2. Date of Death Month Day Year August 20, 1996		3. Time of Death 1:40 A.M.	
	4a. Facility Name (If not institution, give street and number) 701 Maiden Choice Lane				4b. City, Town, or Location of Death Catonsville		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 287-03-2497		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 3, 1907	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Catonsville		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 701 Maiden Choice Lane				10f. Zip Code 21228		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesman		16b. Kind of Business/Industry Union Metal Co.			
	17. Father's Name (First, Middle, Last) John Lang				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Tuttle			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Susan Yohn (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) R.D.2 Menada Bottom Road, Grantsville, Pa 17028			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc.		Date 8-21-96	20c. Location - City or Town, State Catonsville, Md		
	21. Signature of Burial Service Licensee Francis S. Karczmarek		22. Name and Address of Facility McCully Funeral Home of 21122 3204 Mountain Rd, Pasadena, Md Pasadena					
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. END STAGE DEMENTIA Due to (or as a consequence of): YEARS  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ALCOHOLISM HYPERTENSION CONGESTIVE HEART FAILURE						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury et Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Matt J. N. M.D.		29c. License number D44748		29d. Date signed (Month, Day, Year) 8/20/96 AUGUST 20, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 711 MAIDEN CHOICE LANE CATONSVILLE, MD 21228								
31. Date filed (Month, Day, Year) AUG 29 1996		32. Registrar's Signature						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25697

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Geneva R. Liberto</b>		2. Date of Death Month <b>Aug.</b> Day <b>26</b> Year <b>1996</b>		3. Time of Death <b>5:05 PM</b>
	4e. Facility Name (If not institution, give street and number) <b>1105 Dorchester Avenue</b>		4b. City, Town, or Location of Death <b>Woodlawn</b>		4c. County of Death <b>Baltimore</b>
Funeral Director	5. Social Security Number <b>217-12-7853</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Oct. 15, 1921</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10e. State <b>Md.</b>	10b. County <b>Baltimore</b>	10c. City, Town or Location <b>Woodlawn</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>1105 Dorchester Avenue</b>		10f. Zip Code <b>21207</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Waitress</b>		16b. Kind of Business/Industry <b>Restaurant</b>		
	17. Father's Name (First, Middle, Last) <b>Giovoni Lascula</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Maria Santa Presti</b>		
	19e. Informant's Name/Relationship (Type, Print) <b>James J. Liberto (Son)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1105 Dorchester Avenue Woodlawn, Maryland 21207</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Md. Veterans Cemetery</b>		20c. Location - City or Town, State <b>Owings Mills, Maryland</b>
	21. Signature of Funeral Service Licensee <i>Quanta R Thomas</i>		22. Name and Address of Facility <b>Witzke Funeral Homes, Inc. 1630 Edmondson Avenue Catonsville, Maryland</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) <b>e. Small cell lung cancer</b>				<b>1 yr. 4 mos.</b>
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
Medical Certification: To Be Completed by Physician/Medical Examiner	Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
					24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>John Davidson-Randall</i>		29c. License number <b>D40850</b>	29d. Date signed (Month, Day, Year) <b>August 27, 1996</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>VIVIANE OTTAVIANO MD 900 CATON AVE. BALTIMORE MD 21227</b>					
31. Date filed (Month, Day, Year) <b>AUG 29 1996</b>		32. Registrar's Signature <i>John Davidson-Randall</i>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

96 25698

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Gladys Virginia Lineberg

2. Date of Death

Month

Day

Year

3. Time of Death

3:10 PM

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

226-09-8762

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 31, 1915

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Elkridge

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5757 Main Street

10f. Zip Code

21227

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Homemaking

17. Father's Name (First, Middle, Last)

Charles

PITCOCK

18. Mother's Name (First, Middle, Maiden Surname)

Lillian

LINEBERG

19a. Informant's Name/Relationship (Type, Print)

Darlene Crampton/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

312 Lee Drive Catonsville, MD 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Memorial Park

Date

20c. Location - City or Town, State

Dorsey, MD

21. Signature of Funeral Service Licensee

M. H. Coleman

22. Name and Address of Facility

Gary L. Kaufman Funeral Home, Inc.  
5695 Main Street Elkridge, MD 21227

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Bronchopneumonia

Due to (or as a consequence of):

1 week

b. Peritonitis

Due to (or as a consequence of):

3 weeks

c. Ruptured stomach

Due to (or as a consequence of):

3 weeks

d. Intestinal obstruction from adhesions

3-4 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Metastatic adenocarcinoma of rectum involving

liver and lungs.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

William J. Hicken, M.D.

29c. License number

D04964

29d. Date signed (Month, Day, Year)

8/24/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

William J. Hicken, M.D., St. Agnes Hospital, 900 Caton Ave., Baltimore, MD 21229

31. Date filed (Month, Day, Year)

AUG 29 1996

32. Registrar's Signature

John A. Hicken

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

96 25699

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Tyrone D. Leggett</b>				2. Date of Death Month <b>August</b> Day <b>25</b> Year <b>1996</b>		3. Time of Death <b>1:30 AM</b>	
	4e. Facility Name (If not institution, give street and number) <b>John Hopkins Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>NA</b>	
Funeral Director	5. Social Security Number <b>212-08-0781</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>12</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>5-5-84</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10e. State <b>Maryland NA</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>862 W. Pratt Street</b>				10f. Zip Code <b>21201</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th</b> College (1-4or 5+)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Student</b>		16b. Kind of Business/Industry <b>NA</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>LARRY CARR</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>LETITIA HORSEY</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>LETITIA HORSEY (Mother)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>862 W. Pratt Baltimore, Md 21201</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT Zion Cemetery</b>		Date <b>8/30/96</b>	20c. Location - City or Town, State <b>Lansdowne, Md</b>		
	21. Signature of Funeral Service Licensee <b>Jeff Miller</b>				22. Name and Address of Facility <b>JEFF MILLER P.C. FH 1639 N. Broadway</b>			
Physician /Medical Examiner	23e. Pert. Entail the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) <b>a. CEREBRAL HERNIATION</b>							<b>2 DAYS</b>
	Due to (or as a consequence of): <b>b. GLIOBLASTOMA MULTIFORME</b>							<b>2 YEARS</b>
	Due to (or as a consequence of): <b>c.</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Daniel C Bowers MD</b>		29c. License number <b>D-50247</b>		29d. Date signed (Month, Day, Year) <b>August 25 1996</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>DANIEL C. BOWERS MD 600 N. Wolfe Street Div 7 Pediatric Oncology</b>								
31. Date filed (Month, Day, Year) <b>AUG 29 1996</b>		32. Registrar's Signature <b>Don Randall</b>						

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



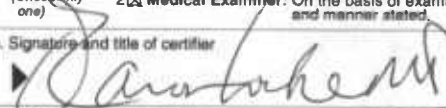
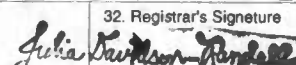
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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25790

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MAMIE C LIMMER</b>		2. Date of Death Month Day Year <b>AUGUST 16, 1996</b>		3. Time of Death <b>2155PM</b>
	4a. Facility Name (If not institution, give street and number) <b>8604 MCDANIEL AVENUE-RESIDENCE</b>		4b. City, Town, or Location of Death <b>ROSEDALE</b>		4c. County of Death <b>BALTIMORE COUNTY</b>
Funeral Director	5. Social Security Number <b>218-46-5043</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>MAY 23, 1912</b>		9. Birthplace (State or Foreign Country) <b>BALTIMORE CO., MD.</b>		
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE COUNTY</b>
	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	10e. Street and Number <b>8604 MCDANIEL ROAD</b>		10f. Zip Code <b>21237</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>N/A</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOUSEWIFE</b>		16b. Kind of Business/Industry <b>HOUSEKEEPING-OWN HOME</b>
	17. Father's Name (First, Middle, Last) <b>FREDERICK BOHLEN</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>AUGUSTA HAWKINS</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>BARRY MORRIS ROTH</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6721 EAST SHARON DRIVE RASKIN ESTATES SCOTTSDALE, ARIZONA 85254</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GARDENS OF FAITH CEMETERY</b>		20c. Location - City or Town, State <b>AUGUST 19, 1996 BALTIMORE, MARYLAND</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>LASSAHN FUNERAL HOME, INC. 7401 BELAIR ROAD BALTIMORE, MARYLAND 21236-4625</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Arteriosclerotic Cardiovascular Disease</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <b>INSPECTION</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 17, 1996</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>AUG 29 1996</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

FilmG738 item 23 per DR 8-29-96 rja

## Certificate of Death

Reg. No.

96 25701

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JERRA LYLES Jr.</b>		2. Date of Death Month <b>AUGUST</b> Day <b>21</b> Year <b>1996</b>		3. Time of Death <b>6:15 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>		4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>219-786529</b>	6. Sex <b>102 M</b> 20 F	7. Age (In yrs. last birthday) <b>34</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>1-13-62</b>		9. Birthplace (State or Foreign Country) <b>MD</b>		
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>
	10d. Inside City Limits 10 Yes 20 No				
	10e. Street and Number <b>2909 Southern Avenue</b>		10f. Zip Code <b>21214</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status 10 Never Married 20 Married 30 Widowed 40 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 10 Yes 20 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 10 Yes 20 No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12+1</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>		16b. Kind of Business/Industry <b>Leon Produce</b>
	17. Father's Name (First, Middle, Last) <b>Jerra Lyles</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Thelma Hardy</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Jerra Lyles Sr.</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2909 Southern Avenue, Baltimore, MD</b>		
	20a. Method of Disposition 10 Burial 20 Cremation 30 Removal from State 40 Donation 50 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Maryland National Cemetery</b>		20c. Location - City or Town, State <b>Laurel, Maryland</b>
	21. Signature of Funeral Service Licensee <b>Jeff Miller</b>		22. Name and Address of Facility <b>Jeff Miller P.C. Funeral Home 1639 W. Broad Way, Baltimore, MD 21213</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>RENAL FAILURE</b> Due to (or as a consequence of): b. <b>Acquired Immune Deficiency Syndrome</b> Due to (or as a consequence of): c. <b>Staphylococcus Arrius Sepsis</b> Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death <b>1 MONTH</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <b>ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)</b> <b>STAPHYLOCOCCUS AUREUS SEPSIS</b>				
	23b. Did tobacco use contribute to the cause of death? 10 Yes 20 No 30 Probably 40 Unknown				
	24a. Was an autopsy performed? 10 Yes 20 No				24b. Were autopsy findings available prior to completion of cause of death? 10 Yes 20 No
	25. Was case referred to medical examiner? 10 Yes 20 No		28. Place of Death (Check only one) Hospital: 10 Inpatient 20 ER/Outpatient 30 DOA Other: 40 Nursing Home 50 Residence 80 Other (Specify)		
	27. Manner of Death 10 Natural 50 Pending investigation 20 Accident 60 Could not be determined 30 Suicide 40 Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>
	28c. Injury at Work? 10 Yes 20 No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
	29b. Signature and title of certifier <b>HOUSE OFFICER</b>		29c. License number <b>00139</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 21, 1996</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>CYRIL RUWENDE</b>		<b>DEPT OF MEDICINE JOHNS HOPKINS HOSPITAL BALTIMORE MD 21205</b>			
31. Date filed (Month, Day, Year) <b>AUG 29 1996</b>		32. Registrar's Signature <b>Julia Davidson-Randall</b>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural" or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Marquerite Lord Mears</b>				2. DATE OF DEATH MONTH DAY YEAR <b>08 27 1996</b>		3. TIME OF DEATH <b>9:45 a.m.</b>	
4. SOCIAL SECURITY NUMBER <b>218-50-7080</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>84</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>06/20/96</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Manor Care Towson</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson, Maryland</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Towson</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>509 Joppa Road</b>				10f. ZIP CODE <b>21286</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Housewife</b>		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Lord</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Alice Hunter</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Albert F.F. Mears, Sr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>132 Greenmeadow Dr. Timonium, Maryland 21093</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Church Hill Cemetery 8/30/96</b>		20c. LOCATION — City or Town, State <b>Church Hill, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Ruck/Towson Funeral Home, Inc. 1050 York Rd. Towson, Maryland 21204</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>insulin dependent diabetes</b> DUE TO (OR AS A CONSEQUENCE OF): <b>dementia, recent ileus from constipation</b> DUE TO (OR AS A CONSEQUENCE OF): DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							Approximate Interval Between Onset and Death <b>7 days</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>dementia, recent ileus from constipation</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>N/A</b>		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>24104</b>		29d. DATE SIGNED (Month, Day, Year) <b>8.27.96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. THEODORE HOUK 7825 YORK RD 21204</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 29 1996</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25703

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FRANK L. MAYRONNE				2. Date of Death Month Day Year AUGUST 27, 1996				3. Time of Death 6:00 P.M.				
	4a. Facility Name (If not institution, give street and number) 909 YARD ARM WAY				4b. City, Town, or Location of Death ANNAPOLIS				4c. County of Death ANNE ARUNDEL				
Funeral Director	5. Social Security Number 577-40-7640		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) SEPT. 4, 1915		9. Birthplace (State or Foreign Country) LOUISIANA				
	Usual Residence of Decedent												
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location ANNAPOLIS				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	10e. Street and Number 909 YARD ARM WAY				10f. Zip Code 21401		10g. Citizen of What Country? UNITED STATES						
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: '41-'69		13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4 or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) U.S. ARMY - RETIRED			16b. Kind of Business/Industry MILITARY					
	17. Father's Name (First, Middle, Last) CLARENCE A. MAYRONNE				18. Mother's Name (First, Middle, Maiden Surname) LAURA MCDONNELL								
	19a. Informant's Name/Relationship (Type, Print) MARGARET E. MAYRONNE / WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 909 YARD ARM WAY, ANNAPOLIS, MARYLAND 21401								
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CROWNSVILLE MD VET. CEM.		20c. Date AUG. 30, 1996		20d. Location - City or Town, State CROWNSVILLE, MARYLAND						
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Prostate Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 4 years		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. Signature and title of certifier 						29c. License number D27388			29d. Date signed (Month, Day, Year) AUGUST 28, 1996				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. Stephen Hansman 200 HARRY S. TRUMAN PKWY., ANNAPOLIS, MD 21401													
31. Date filed (Month, Day, Year) AUG 29 1996				32. Registrar's Signature 									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

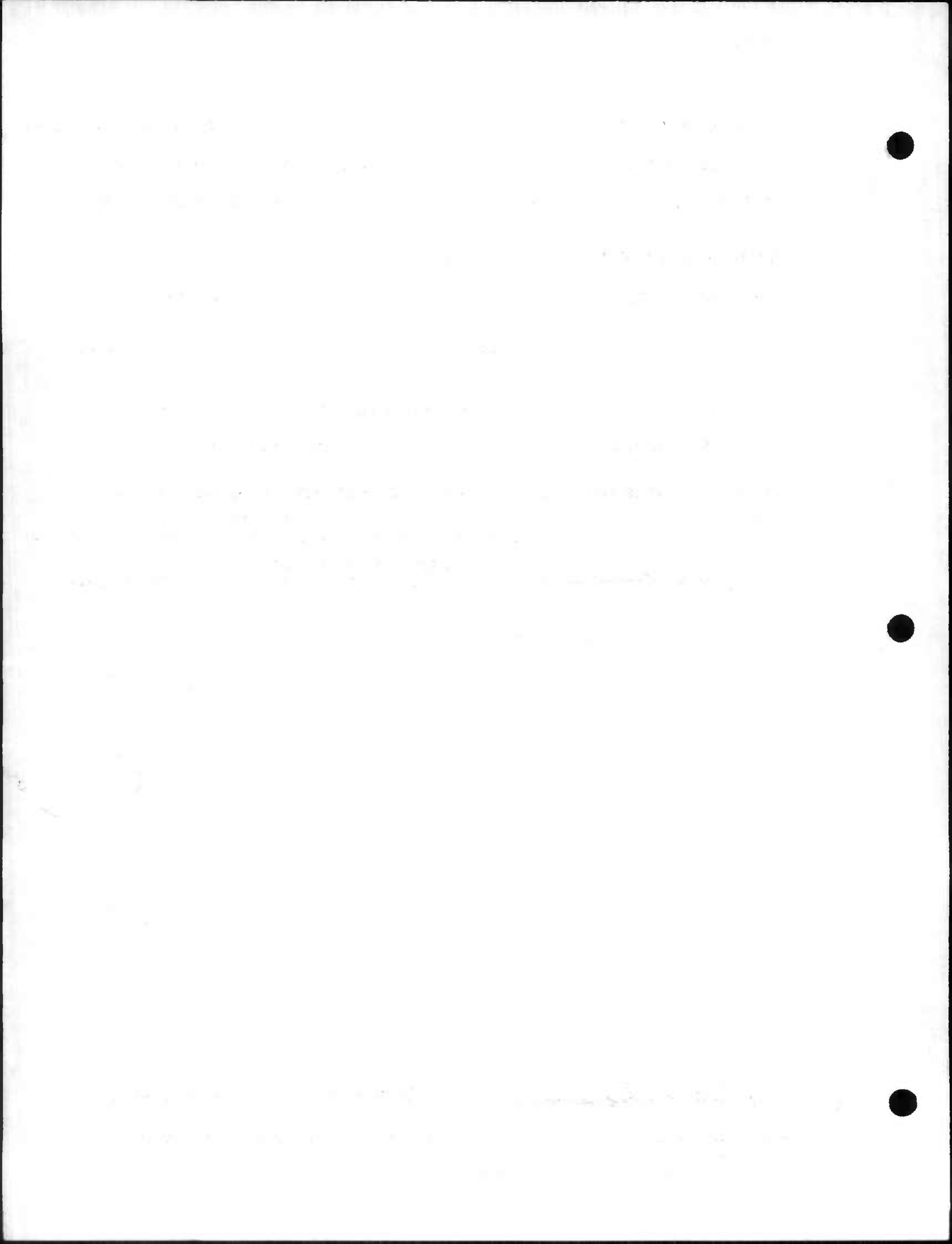
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Nora Messina				2. DATE OF DEATH MONTH DAY YEAR August 26, 1996				3. TIME OF DEATH 10:45 A. M.	
4. SOCIAL SECURITY NUMBER 215-10-8629		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 87 YRS.	7. DATE OF BIRTH (Month, Day, Year) July 22, 1909		8. BIRTHPLACE (State or Foreign Country) Baltimore, Md.			
9a. FACILITY NAME (If not institution, give street and number) 3 Southerly Court Apt. #208				9b. CITY, TOWN OR LOCATION OF DEATH Towson				9c. COUNTY OF DEATH Baltimore Co.	
10a. STATE Maryland				10b. COUNTY Baltimore Co.		10c. CITY, TOWN OR LOCATION Towson		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 3 Southerly Court Apt. #208				10f. ZIP CODE 21286		10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5 +)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Home Maker		16b. KIND OF BUSINESS/INDUSTRY Own Home					
17. FATHER'S NAME (First, Middle, Last) William Cary				18. MOTHER'S NAME (First, Middle, Maiden Surname) Nora Riepe					
19a. INFORMANT'S NAME (Type/Print) Mr. Julius A. Messina (Husband)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Southerly Court Apt. # 208 Towson, Md. 21286					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mem. Gardens 8/30/96		20c. LOCATION — City or Town, State Timonium, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Jeffrey L. Gair				22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204					
23. PART I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Alzheimer's Disease a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER J. J. J. MD							
29c. LICENSE NUMBER D19166		29d. DATE SIGNED (Month, Day, Year) 8/27/96							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ALAN BALDANZA 10629 YORK ROAD, TOWSON, MD. 21030									
31. DATE FILED (Month, Day, Year) AUG 29 1996		32. REGISTRAR'S SIGNATURE Julia Davidson-Rendell							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25705

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MADELINE A. MERSINGER

2. Date of Death

Month Day Year  
AUG 29 1996

3. Time of Death

0815

4a. Facility Name (If not institution, give street and number)

Lorien Nursing Home

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard County

Funeral  
Director

5. Social Security Number

213-05-5811

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 20, 1907

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard County

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4850 Wharff Lane

10f. Zip Code

21043

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

unknown

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

cafeteria worker

16b. Kind of Business/Industry

school cafeteria

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

Mr. Anthony Mello/guardian

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8085 Hillrise Court, Elkridge, MD 21227

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

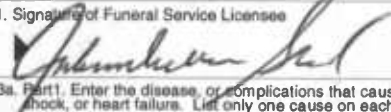
Meadowridge Memorial Pk. 8-31-96

Date

20c. Location - City or Town, State

Elkridge, MD

21. Signature of Funeral Service Licensee



MO0535

22. Name and Address of Facility

Slack Funeral Home, P.A.  
Ellicott City, Maryland23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Aspiration pneumonia

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

3 days

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. oropharyngeal dysfunction

Due to (or as a consequence of):

July 96

c. Stroke (CVA)

Due to (or as a consequence of):

July 96

d. Critical aortic stenosis

Due to (or as a consequence of):

July 96

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

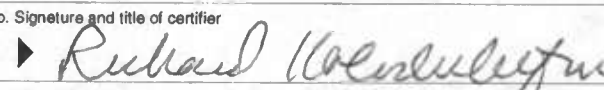
M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)

29b. Signature and title of certifier



29c. License number

D 31575

29d. Date signed (Month, Day, Year)

August 29, 1996

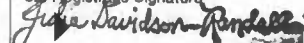
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KOLG DRUG SETZ 5501 Old Annapolis Road Ellicott City MD 21042

31. Date filed (Month, Day, Year)

AUG 29 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25706

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SAMUEL</b>			2. Date of Death Month <b>AUGUST</b> Day <b>27</b> Year <b>1996</b>			3. Time of Death <b>1635</b>		
	4a. Facility Name (If not institution, give street and number) <b>Church Home Hospital</b>			4b. City, Town, or Location of Death <b>Baltimore</b>			4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>251-05-1187</b>			6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>82</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>March 10, 1914</b>	
	9. Birthplace (State or Foreign Country) <b>North Carolina</b>			10a. State <b>Maryland</b>			10b. County <b>N/A</b>		
To Be Completed by Funeral Director	10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			10e. Street and Number <b>201 N. Broadway Apt. 19H</b>		
	10f. Zip Code <b>21231</b>			10g. Citizen of What Country? <b>USA</b>			11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		
To Be Completed by Physician/Medical Examiner	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Negro</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5</b> College (1-4 or 5+) <b>0</b>			18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Driver</b>			16b. Kind of Business/Industry <b>Produce Co.</b>		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Eddie Crowe</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Bessie Mobley</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Beverly Vines</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>420 N. Castle St. Balto, Md. 21231</b>					
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Zion</b>			20c. Location - City or Town, State <b>Lansdowne, Md</b>		
	21. Signature of Funeral Service Licensee <b>Joseph L. Russ</b>			22. Name and Address of Facility <b>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto, Md. 21216</b>					
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Lung Cancer</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>COPD</b>			23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Pneumonia</b> <b>COPD</b>					
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)			28b. Time of Injury <b>M</b>		
To Be Completed by Physician/Medical Examiner	28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			28d. Describe how Injury occurred			28e. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier <b>Dr. Navarro</b>			29c. License number <b>D 40356</b>		
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) <b>AUGUST, 27, 1996</b>			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>D. NAVARRO 100 N. Broadway, Baltimore, MD. 21231</b>					
	31. Date filed (Month, Day, Year) <b>AUG 29 1996</b>			32. Registrar's Signature <b>John Andrew Rodak</b>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25707

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BETTY

JEAN

MILLER

2. Date of Death

AUGUST 26, 1996

3. Time of Death

21:10 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

4407 ETHEL AVE

4b. City, Town, or Location of Death

HAMPSTEAD

4c. County of Death

CARROLL

5. Social Security Number

217-48-1871

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

51

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
04-15-1945

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

CARROLL

10c. City, Town or Location

HAMPSTEAD

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4407 ETHEL AVENUE

10f. Zip Code

21074

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MARKETING

16b. Kind of Business/Industry

SALES

17. Father's Name (First, Middle, Last)

THOMAS

B.

SPAFFORD

18. Mother's Name (First, Middle, Maiden Surname)

THELMA

M.

JARRELL

19a. Informant's Name/Relationship (Type, Print)

THOMAS B. SPAFFORD (FATHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. BOX 147, MERRY POINT, VIRGINIA 22513

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GLEN HAVEN MEMORIAL PARK 8/29/96 GLEN BURNIE, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility SINGLETON FUNERAL HOME,  
1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Contact Gunshot wound of Head

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

Limited to Head  
1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☒ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

8-26-96

28b. Time of Injury

unk M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Self Inflicted

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

4407 Ethel Avenue

Hampstead, Maryland

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Stephen S. Radeniz, M.D.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

AUGUST 27, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen S. Radeniz, M.D. 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 29 1996

32. Registrar's Signature

Julia Davidson-Rendell

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25708

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>EDWARD ANTHONY MAGROWSKY</b>				2. Date of Death Month Day Year <b>AUGUST 25, 1996</b>		3. Time of Death <b>11:20 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>612 SANDY RIDGE DRIVE</b>				4b. City, Town, or Location of Death <b>FERNDAL</b>		4c. County of Death <b>ANNE ARUNDEL</b>	
Funeral Director	5. Social Security Number <b>172-18-6370</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>76</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>05-01-1920</b>	9. Birthplace (State or Foreign Country) <b>PENNSYLVANIA</b>	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>	10b. County <b>ANNE ARUNDEL</b>	10c. City, Town or Location <b>FERNDAL</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>612 SANDY RIDGE DRIVE</b>			10f. Zip Code <b>21061</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>N/A</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>FACTORY WORKER</b>		16b. Kind of Business/Industry <b>ELECTRICAL</b>			
	17. Father's Name (First, Middle, Last) <b>JOHN MAGROWSKY</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>VIRGINIA (UNKNOWN)</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>STEPHEN MAGROWSKY (SON)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>612 SANDY RIDGE DRIVE, FERNDAL, MD. 21061</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CEDAR HILL CEMETERY</b>		20c. Location - City or Town, State <b>8/29/96 BROOKLYN PARK, MD.</b>			
	21. Signature of Funeral Service Licensee		22. Name and Address of Facility <b>SINGLETON FUNERAL HOME 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Metastatic Colon Carcinoma</b> Due to (or as a consequence of): <b>b. with Intracranial Metastases</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d. Colon Cancer</b>							Approximate Interval Between Onset and Death <b>7 mos</b>  <b>2 yrs 7 mos</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Prostate Carcinoma</b>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Russell A. DeLuca</b>		29c. License number <b>031551</b>		29d. Date signed (Month, Day, Year) <b>August 27, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Russell A. DeLuca, 1600 S. Crain Highway, Glen Burnie, Md. 21061</b>								
31. Date filed (Month, Day, Year) <b>AUG 29 1996</b>		32. Registrar's Signature <b>J. Davidson-Randall</b>						

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed, file it in by the funeral director, page 2 should be detached for use as the burial-transit card.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed, file it in by the funeral director, page 2 should be detached for use as the burial-transit card.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25709

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William S. Moore, Jr.				2. Date of Death Month Day Year Aug. 26, 1996		3. Time of Death 3:35 p.m.						
	4e. Facility Name (If not institution, give street and number) North Arundel Hospital				4b. City, Town, or Location of Death Glen Burnie,		4c. County of Death Anne Arundel						
Funeral Director	5. Social Security Number 216-36-8046		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 56 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 28, 1939						
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Millersville						
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 45 Waterford Road		10f. Zip Code 21108							
10g. Citizen of What Country? U.S.A.		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:							
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assembleman		16b. Kind of Business/Industry General Electric							
17. Father's Name (First, Middle, Last) William S. Moore, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Katherine Barrett									
19a. Informant's Name/Relationship (Type, Print) Sandra Lynn Moore				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45 Waterford Road Millersville, Maryland 21108									
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Mem. Park		Date Aug. 30, 1996		20c. Location - City or Town, State Glen Burnie, Maryland							
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility McCully Funeral Home 3204 Mountain Road Pasadena, Maryland 21122									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Due to (or as a consequence of):             Due to (or as a consequence of):             Due to (or as a consequence of):             Due to (or as a consequence of):         </td> <td>a. <u>Stroke</u></td> <td rowspan="4">           Approximate interval Between Onset and Death             3d             1y         </td> </tr> <tr> <td>b. <u>Hypertension</u></td> </tr> <tr> <td>c.</td> </tr> <tr> <td>d.</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	a. <u>Stroke</u>	Approximate interval Between Onset and Death  3d  1y	b. <u>Hypertension</u>	c.	d.
Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	a. <u>Stroke</u>	Approximate interval Between Onset and Death  3d  1y											
	b. <u>Hypertension</u>												
	c.												
	d.												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown													
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)													
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No							
28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. Signature and title of certifier 				29c. License number D 41197		29d. Date signed (Month, Day, Year) 8/28/96							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAMUEL MILLER MD 18 William Ave													
31. Date filed (Month, Day, Year) AUG 29 1996				32. Registrar's Signature 									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

12

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25710

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JUANITA GALLAGHER McCAIG

2. Date of Death

Month Day Year  
AUGUST 23, 1996

3. Time of Death

3:50pm

4a. Facility Name (If not institution, give street and number)

4213 CLUB COURT

4b. City, Town, or Location of Death

ELLIOTT CITY

4c. County of Death

HOWARD

Funeral  
Director

5. Social Security Number

214-22-7998

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

68

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JAN 11, 1928

9. Birthplace (State or Foreign Country)

IOWA

Usual Residence of Decedent

10a. State

MD

10b. County

HOWARD

10c. City, Town or Location

ELLIOTT CITY

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4213 CLUB COURT

10f. Zip Code

21042

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 YRS

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

PROFESSIONAL REGISTERED NURSE

16b. Kind of Business/Industry

ANNE ARUNDEL COUNTY  
BOARD OF EDUCATION

17. Father's Name (First, Middle, Last)

WILLIAM GALLAGHER

18. Mother's Name (First, Middle, Maiden Surname)

LORETTA HEINE

19a. Informant's Name/Relationship (Type, Print)

DONALD G. McCAIG (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2708 MERCER DRIVE - BALDWIN, MD. 21013

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory, or other place)

BALTO NAT'L CEMETERY

Date

8/27/96

20c. Location - City or Town, State

LAUREL

21. Signature of Funeral Service Licensee

Jackie H. Shannon

22. Name and Address of Facility

HUBBARD FUNERAL HOME, INC.

4107 WILKENS AVENUE-BALTIMORE, MD

21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)e. Pneumonia  
Due to (or as a consequence of):b. Atrial Fibrillation  
Due to (or as a consequence of):c. Diabetes Mellitus  
Due to (or as a consequence of):d. Multi-infarct dementia  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

2 days

years

years

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office,  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

DR. CHERYL BURK

29c. License number

M-42998

29d. Date signed (Month, Day, Year)

August 23, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. CHERYL BURK

4801 DORSEY HALL DRIVE - SUITE 201-B - ELLIOTT CITY, MD. 21042

31. Date filed (Month, Day, Year)

AUG 29 1996

32. Registrar's Signature

J. A. [Signature]

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25711

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

VIRGINIA S. MANGER

2. Date of Death

Month Day Year  
AUGUST 18, 1996

3. Time of Death

4:15 P.M.

4a. Facility Name (If not institution, give street and number)

ST. ELIZABETH'S NURSING HOME

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

217-38-3681

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
OCT 16, 1913

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

CATONSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

331 WESSLING CIRCLE

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12TH GRADE

College (1-4or 5+)

16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

MERCHANT

16b. Kind of Business/Industry

MEAT BUSINESS

17. Father's Name (First, Middle, Last)

WILLARD SHERMAN

18. Mother's Name (First, Middle, Maiden Surname)

CORA FIELDS

19a. Informant's Name/Relationship (Type, Print)

VERNON F. MANGER (HUSBAND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

331 WESSLING CIRCLE - CATONSVILLE, MD 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

LOUDON PARK CEMETERY

Date

8/22/96

20c. Location - City or Town, State

BALTIMORE

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HUBBARD FUNERAL HOME, INC.

4107 WILKENS AVENUE-BALTIMORE, MD 21229

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. THROMBOTIC STROKE LEFT HEMISPHERE

Approximate  
Interval Between  
Onset and Death

3 MONTHS

Due to (or as a consequence of):

b. HYPERTENSIVE ARTERIOSCLEROTIC CEREBRAL DISEASE

YEARS

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, term, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

DO 1786

29d. Date signed (Month, Day, Year)

AUGUST 18, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DR. LAURENCE R. GALLAGHER - 3455 WILKENS AVENUE - SUITE 300 - BALTIMORE, MD 21229

31. Date filed (Month, Day, Year)

AUG 29 1996

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



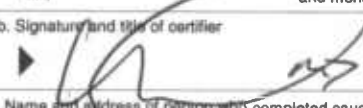
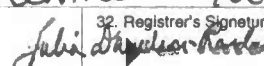
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25712

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FRANCES S. MONROE</b>				2. Date of Death Month Day Year <b>AUGUST 20, 1996</b>		3. Time of Death <b>16:10 P.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>St. Agnes Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>242-40-3968</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>76</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>JUNE 24, 1920</b>	9. Birthplace (State or Foreign Country) <b>West Virginia</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>Md.</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Saint Denis</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>5123 Viaduct Avenue</b>				10f. Zip Code <b>21227</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+) <b></b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>				
	17. Father's Name (First, Middle, Last) <b>Edward Smith</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>Mary E. Henson</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Robert Monroe</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>41 Reile Drive, Elkridge, Md. 21227</b>				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Louden Park Cemetery</b>		Date <b>8/23/96</b>		20c. Location - City or Town, State <b>Baltimore, Md.</b>		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Gary L. Kaufman Funeral Home of Elk., Inc. 5695 Main Street, Elkridge, Md. 21227</b>				
	23a. Part I. Enter the disease, or complications that resulted in the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>respiratory arrest</b> Due to (or as a consequence of): b. <b>bowel obstruction</b> Due to (or as a consequence of): c. <b>acidosis</b> Due to (or as a consequence of): d. <b>bradycardia</b>								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic obstructive pulmonary disease</b>								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  Physician		29c. License number <b>D50708</b>		29d. Date signed (Month, Day, Year) <b>8/20/96 August 20, 1996</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Kraig Arthur Melville 900 South Canton Ave, Baltimore, Maryland</b>									
31. Date filed (Month, Day, Year) <b>AUG 9 1996</b>				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

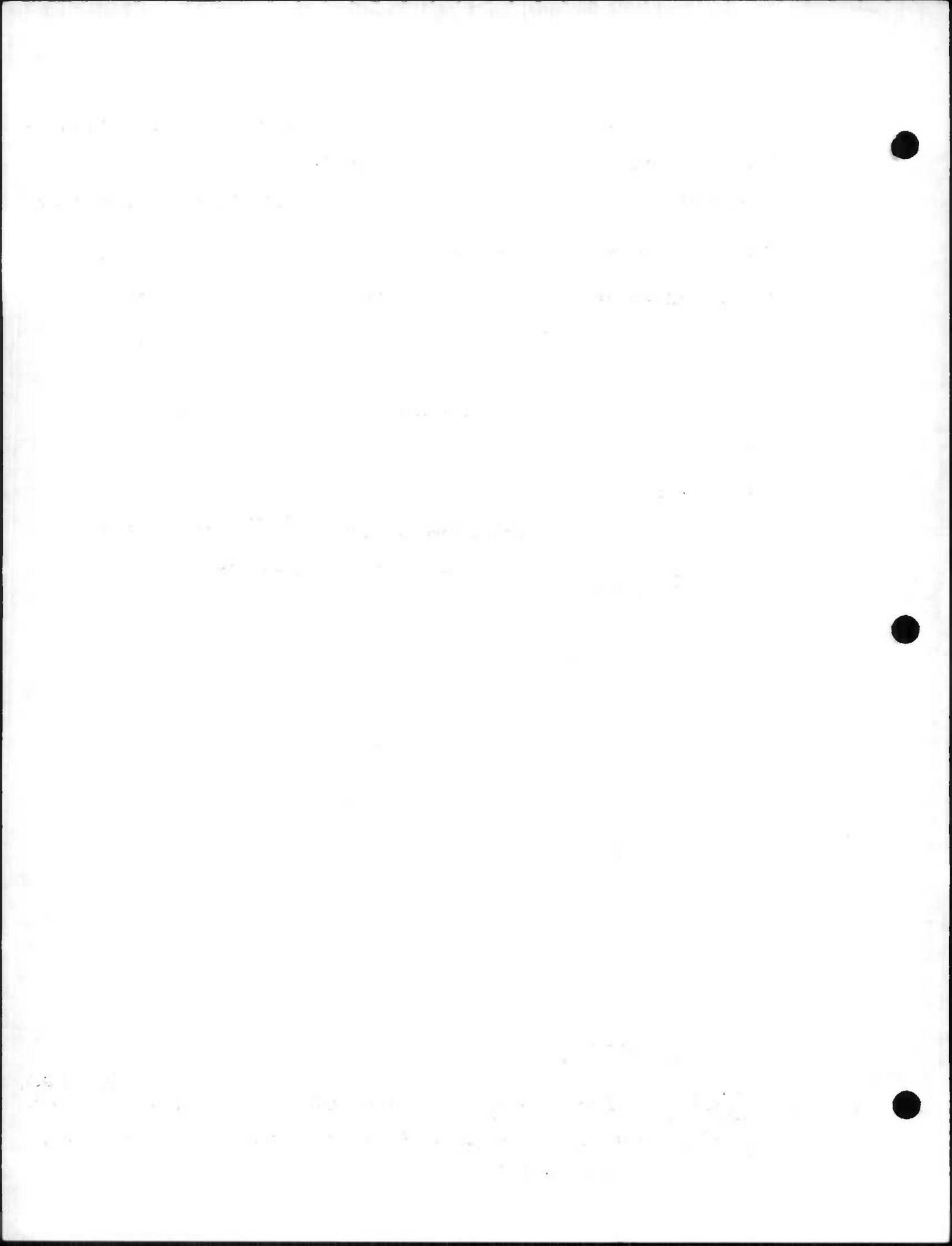
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner


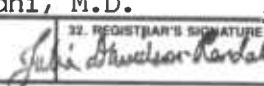
State  
Registrar



96 25713

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Fred McKinney				2. DATE OF DEATH August 20, 1996		3. TIME OF DEATH 3:21P	
4. SOCIAL SECURITY NUMBER 420-07-3564		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) SEP. 13, 1919	
9a. FACILITY NAME (If not institution, give street and number) VA Maryland Health Care System				9b. CITY, TOWN OR LOCATION OF DEATH Perry Point		9c. COUNTY OF DEATH Cecil	
RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY Howard		10c. CITY, TOWN OR LOCATION Columbia		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 8858 Tamebird Court				10f. ZIP CODE 21045		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1950-1966		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Veteran		16b. KIND OF BUSINESS/INDUSTRY United States Army			
17. FATHER'S NAME (First, Middle, Last) James McKinney, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Julia Pope			
19a. INFORMANT'S NAME (Type/Print) Diane Nelson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8858 Tamebird Court, Columbia, Md. 21045			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Crownsville Veterans Cem. 8/23		20c. LOCATION — City or Town, State Crownsville, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Gary L. Kaufman Funeral Home of Elk., Inc. 5695 Main St., Elkridge, Md. 21227			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Severe Aspiration Pneumonia DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death unknown							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER S. Sodhi				29c. LICENSE NUMBER D42014		29d. DATE SIGNED (Month, Day, Year) 08/20/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Surinderpal Sodhi, M.D. Perry Point, MD 21902							
31. DATE FILED (Month, Day, Year) AUG 20 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Certificate of Death

96 25714

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret McGee				2. Date of Death Month 8 Day 27 Year 96		3. Time of Death 1030 AM		
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 218-28-7308		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 63 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) NOV. 11, 1932	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Md.		10b. County Baltimore		10c. City, Town or Location Dundalk			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 103 Center Place, Apt. 216				10f. Zip Code 21222		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) William H. McQuade				18. Mother's Name (First, Middle, Maiden Surname) Freda A. Lorenz				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mary Lansella - sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6810 Bel Clare Rd., Baltimore, Md. 21222				
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		Date 8/29/96		20c. Location - City or Town, State Beltsville, Maryland		
	21. Signature of Funeral Service Licensee				22. Name and Address of Facility Gary L. Kaufman Funeral Home of Elk., Inc. 5695 Main St., Elkridge, Md. 21227				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. End stage congestive heart failure Due to (or as a consequence of): b. Cardiomyopathy Due to (or as a consequence of): c. Coronary artery disease Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 2 yrs 2 yrs 2 yrs	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Hyon Seo M.D.		29c. License number 96712		29d. Date signed (Month, Day, Year) 8/27/96			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Hyon Seo 4940 Eastern Ave Baltimore, MD 21224									
31. Date filed (Month, Day, Year) AUG 29 1996		32. Registrar's Signature John Shuckler-Randall							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25715

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MAURICE F. MORRISON</b>		2. Date of Death Month <b>AUGUST</b> Day <b>20</b> Year <b>1996</b>		3. Time of Death <b>2:15 A</b>
	4a. Facility Name (If not institution, give street and number) <b>2400 BLK LLEWELYN AVE (rear)</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>214-92-5762</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>17</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>8-29-78</b>		9. Birthplace (State or Foreign Country) <b>MD</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <b>MD</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>2431 E. Hoffman Street</b>		10f. Zip Code <b>21213</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>(Black)</b>
	14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th</b> Collage (1-4or 5+) <b></b>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Student</b>		16b. Kind of Business/Industry <b>N/A</b>		
	17. Father's Name (First, Middle, Last) <b>Godfrey Morrison</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Bernadette Brown</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Bernadette Morrison (Mother)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2431 E. Hoffman Street</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Baltimore Cemetery</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>
	21. Signature of Funeral Service Licensee <i>Jeff Miller</i>		22. Name and Address of Facility <b>JEFF MILLER P.C. F/H 1639 N. Broadway Baltimore, Maryland (21213)</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediata Causa (Final disease or condition resulting in death) <b>a. Gunshot Wounds of Head</b> Dua to (or as a consequence of):  Sequentially list conditions, if any, leading to Immediata causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. </b> Dua to (or as a consequence of): <b>c. </b> Dua to (or as a consequence of): <b>d. </b>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>8-20-96</b>			
28b. Time of Injury <b>2:05 AM</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
28d. Describe how injury occurred <b>subject shot</b>		28e. Location (Street and Number or Rural Route Number, City or Town, State) <b>Baltimore, MD</b>			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <i>Dennis J. Chute MD</i>		29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 20, 1996</b>	
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>AUG 29 1996</b>		32. Registrar's Signature <i>William R. Riddell</i>			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25716

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Elester Nash, Jr.</b>						2. Date of Death Month <b>Aug.</b> Day <b>27</b> Year <b>1996</b>		3. Time of Death <b>7:40 Am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Bon Secours Hosp. Inc.</b>						4b. City, Town or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>212-42-7722</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>50</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 11, 1946</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>345 S. Bentalou Street</b>				10f. Zip Code <b>21223</b>		10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>Vietnam</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Telephone Solicitor</b>		16b. Kind of Business/Industry <b>Telemarketing</b>				
17. Father's Name (First, Middle, Last) <b>Elester Howard Nash, Sr.</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Katherine Leola Cox</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Katherine L. Wroy/Mother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>345 S. Bentalou St. Baltimore, MD 21223</b>						
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc.</b>		Date <b>08/28/96</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>				
21. Signature of Funeral Service Licensee <b>F. McDonald</b>				22. Name and Address of Facility <b>Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228</b>						
23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
Immediate Cause (Final disease or condition resulting in death) a. <b>Bilateral cerebrovascular accident</b> Due to (or as a consequence of): b. <b>Staphylococcal Endocarditis</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Renal Failure</b>										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Markus Galicia MD</b>		29c. License number <b>D15698</b>		29d. Date signed (Month, Day, Year) <b>Aug. 27, 1996</b>				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>MARCOS GALICIA MD Bon Secours Hospital, Balt. MD 21223</b>										
31. Date filed (Month, Day, Year) <b>AUG 29 1996</b>		32. Registrar's Signature <b>John A. Wilson-Randall</b>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25717

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN A. OLIVER, JR.

2. Date of Death

Month Day Year

27 1996

3. Time of Death

07:35 PM

4a. Facility Name (If not institution, give street and number)

ST. AGNES HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

214-20-8086

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

JULY 10, 1926

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2007 GRINNALDS AVENUE

10f. Zip Code

21230

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No  
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10TH GRADE

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CRANE OPERATOR

16b. Kind of Business/Industry

STEEL MANUFACTURER

17. Father's Name (First, Middle, Last)

JOHN A. OLIVER, SR.

18. Mother's Name (First, Middle, Maiden Surname)

AGNES MORRISSEY

19. Informant's Name/Relationship (Type, Print)

VIRGINIA OLIVER (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2007 GRINNALDS AVENUE - BALTIMORE, MD 21230

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD VETS CEMETERY CROWNSVILLE

Date

8/30/96

20c. Location - City or Town, State

CROWNSVILLE, MD

21. Signature of Funeral Service Licensee

*M. Neal Coleman*

22. Name and Address of Facility

HUBBARD FUNERAL HOME, INC.

4107 WILKENS AVENUE-BALTIMORE, MD

21229

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIOMYOPATHY

Due to (or as a consequence of):

b. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

> 3 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

26. Place of Death (Check only one)

☐ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28e. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*Thaw Poov, MD*  
*FOR DR. MORGAN, Cardiologist*

29c. License number

PO 9142

29d. Date signed (Month, Day, Year)

AUG 27 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thaw Poov, 900 Caton Ave, Baltimore, MD 21229

31. Date filed (Month, Day, Year)

AUG 29 1996

32. Registrar's Signature

*J. A. Davidson*

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





96-4813-047

96-192

B.K.S

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEMS: 23 PART I, 27, State of Maryland / Department of Health and Mental Hygiene

28a-f, PER MEO F'ILM G-739 9/13/96 t.t

Certificate of Death

Reg. No.

96 25718

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GEORGE

ROBERT

PRICE, JR

2. Date of Death

Month Day Year

AUG. 24, 1996

3. Time of Death

8:10 AM

4a. Facility Name (If not institution, give street and number)

STINKY BEACH- WEST OF OCEAN CITY

4b. City, Town, or Location of Death

Ocean City

4c. County of Death

WORCESTER

Funeral  
Director

5. Social Security Number

222-54-4802

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

37

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

April 15, 1959

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Virginia

10b. County

Northampton

10c. City, Town or Location

Capeville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

Box 92

10f. Zip Code

23313

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Contractor

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

George Robert Price

18. Mother's Name (First, Middle, Maiden Surname)

Kathryn Elliott

19a. Informant's Name/Relationship (Type, Print)

Kathryn E. Costin/mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Box 92 Townsend, VA 23313

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metro Crematory, Inc. 08/28/96

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

George E. MacNabb

22. Name and Address of Facility

Wilkins-Doughty Funeral Home  
119 Pine St., Cape Charles, VA 2331023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

DROWNING ASSOCIATED WITH ACUTE ALCOHOL INTOXICATION

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
☒ Yes 2 ☐ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☒ Other (Specify) WATER

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☒ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)

FOUND 8-24-96

28b. Time of  
Injury atFOUND AT  
8:10 A M28c. Injury at  
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

UNKNOWN

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)

FOUND IN WATER

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

STINKY BEACH

OCEAN CITY, MARYLAND

29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dennis J. Chuteau

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

AUG, 25, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis J. Chuteau

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 29 1996

32. Registrar's Signature

Dennis J. Chuteau

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25719

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Frieda Ponczak</i>				2. Date of Death Month Day Year <i>August 26, 1996</i>		3. Time of Death <i>3:30pm</i>	
	4a. Facility Name (If not institution, give street and number) <b>6332 AMHERST AVENUE</b>				4b. City, Town, or Location of Death <b>COLUMBIA</b>		4c. County of Death <b>HOWARD</b>	
Funeral Director	5. Social Security Number <b>214-44-0198</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>54</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>MAR. 5, 1942</b>	9. Birthplace (State or Foreign Country) <b>POLAND</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>		10b. County <b>HOWARD</b>		10c. City, Town or Location <b>COLUMBIA</b>		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number <b>6332 AMHERST AVE.</b>				10f. Zip Code <b>21046</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4or 5+) <b>2</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>REALTOR</b>		16b. Kind of Business/Industry <b>REAL ESTATE</b>		
	17. Father's Name (First, Middle, Last) <b>MORRIS GREENBLATT</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ANNA MONCHARZ</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>MR. SAMUEL PONCZAK (HUSBAND)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6332 AMHERST AVENUE COLUMBIA, MD 21046</b>			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BALTIMORE HEBREW</b>		Data <b>8-28-1996-</b>		20c. Location - City or Town, State <b>REISTERSTOWN, MD</b>	
	21. Signature of Funeral Service Licenses <i>[Signature]</i>				22. Name and Address of Facility <b>Sol Levinson &amp; Bros., Inc. 8900 Reisterstown Road Pikesville, MD 21208</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. METASTATIC PANCREATIC CARCINOMA</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>							
	23b. Approximate Interval Between Onset and Death <b>YEARS</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
28d. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and Title of certifier <i>[Signature]</i>				29c. License number <b>D22856</b>		29d. Date signed (Month, Day, Year) <b>August 26, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JEFFREY I. LEVINSON MD 11055 Little Patuxent Pkwy, Columbia, MD 21046</b>								
31. Date filed (Month, Day, Year) <b>AUG 29 1996</b>		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020  
 Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



96 25720

DMMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25721

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARtha Lee POTTS

2. Date of Death

August 27 1996 1:36 PM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Harbor Hospital Medical Center Baltimore City

4b. City, Town, or Location of Death

4c. County of Death

N/A

5. Social Security Number

279-32-9890

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

60

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

02-06-1936

9. Birthplace (State or Foreign Country)

OHIO

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

LINTHICUM HEIGHTS

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

413 SHIPLEY ROAD

10f. Zip Code

21090

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

FLORAL DESIGNER

16b. Kind of Business/Industry

FLORIST

17. Father's Name (First, Middle, Last)

GERALD

LEE

MILLER

18. Mother's Name (First, Middle, Maiden Surname)

HANNAH

MARTHA

BOYD

19a. Informant's Name/Relationship (Type, Print)

JOHN WAYSON, JR. (FRIEND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

322 SCHOOL LANE, LINTHICUM, MARYLAND 21090

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

SHARON CEMETERY

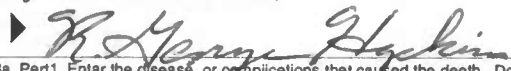
Date

9/1/96

20c. Location - City or Town, State

CALDWELL, OHIO

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

SINGLETON FUNERAL HOME,

1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metabolic Acidosis/Respiratory Acidosis

unknown

Due to (or as a consequence of):

b. Wegners Granulomatosis

2 yrs

Due to (or as a consequence of):

c. chronic Renal failure

2 yrs

Due to (or as a consequence of):

d. COPD (Chronic Obstructive Pulmonary Disease)

unknown

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

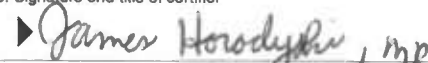
29a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

A52441616

29d. Date signed (Month, Day, Year)

August 27, 1996

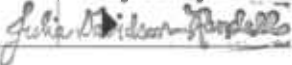
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James Horodyski 3601 S. Hanover St Baltimore, MD 21230

31. Date filed (Month, Day, Year)

AUG 29 1996

32. Registrar's Signature


State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

OFFICE OF THE SECRETARY OF THE ARMY

WASHINGTON, D. C. 20315

MEMORANDUM FOR THE SECRETARY

SUBJECT: [Illegible]

Very truly yours,  
[Illegible Signature]



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25722

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) STANLEY JOHN POLYANSKI, JR.				2. Date of Death Month Day Year Aug. 26, 1996		3. Time of Death 11:00 PM	
	4a. Facility Name (If not institution, give street and number) 821 Pontiac Avenue, 21225				4b. City, Town, or Location of Death Baltimore City		4c. County of Death N/A	
Funeral Director	5. Social Security Number 215-07-4069		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) July 21, 1909	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore (Brooklyn)	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 821 Pontiac Avenue		10f. Zip Code 21225		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4or 5+) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Retired Burner/Welder		16b. Kind of Business/Industry Bethlehem Steel Corp.			
	17. Father's Name (First, Middle, Last) Stanley John Polyanski, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Ona (ANNIE) Vincekevich			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mr. Stanley J. Polyanski, III				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6404 Carrick Place, Temple Hills, Md. 20748			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Cross Cemetery		20c. Date Aug. 30, 1996		20d. Location - City or Town, State Baltimore, Maryland	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Kevin E. Ecker				22. Name and Address of Facility McCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Balto., Md. 21225-1856			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  immediate Cause (Final disease or condition resulting in death) a. <u>Acute Cardiac Arrest</u> Due to (or as a consequence of): b. <u>Acute Myocardial Infarction</u> Due to (or as a consequence of): c. <u>Atherosclerotic Heart Disease</u> Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death <u>Immediate</u> "			
Division of Vital Records, P.O. Box 68760,	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Asthma</u>				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To the Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
State Registrar	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Colvin Carter, M.D.		29c. License number D01459		29d. Date signed (Month, Day, Year) August 28, 1996	
DHMH 16 Rev 6/95	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Colvin C. Carter, M.D., 4710 Pennington Ave., Baltimore, Maryland 21226				31. Date filed (Month, Day, Year) AUG 29 1996			
	32. Registrar's Signature							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>AGNES HEIDE PAUGH</b>				2. Date of Death Month <b>AUGUST</b> Day <b>25</b> Year <b>1996</b>		3. Time of Death <b>4:40 P.M.</b>								
	4a. Facility Name (If not institution, give street and number) <b>625 CROSBY ROAD</b>				4b. City, Town, or Location of Death <b>WOODLAWN</b>		4c. County of Death <b>BALTIMORE</b>								
Funeral Director	5. Social Security Number <b>214-98-2540</b>		8. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>36</b> Yrs.		6. Data of Birth (Month, Day, Year) <b>Nov. 28, 1959</b>								
	9. Birthplace (State or Foreign Country) <b>Germany</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Woodlawn</b>								
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>625 Crosby Road</b>		10f. Zip Code <b>21228</b>		10g. Citizen of What Country? <b>U.S.A.</b>							
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>									
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (14 or 5+) <b>N/A</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Assembler</b>		16b. Kind of Business/Industry <b>Atlas Co.</b>		17. Father's Name (First, Middle, Last) <b>John W. Paugh</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Irmgard Kustmann</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Mr. John W. Paugh</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1425 Isted Road Glen Burnie, Maryland 21060</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery Aug. 28, 1996</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>							
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>McCully Funeral Home 3204 Mountain Road Pasadena, Maryland 21122</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>SEIZURE DISORDER</b> Due to (or as a consequence of):  <b>ARTERIOVENOUS MALFORMATION OF BRAIN</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  <b>SEIZURE DISORDER</b> Due to (or as a consequence of):  <b>ARTERIOVENOUS MALFORMATION OF BRAIN</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  <b>SEIZURE DISORDER</b> Due to (or as a consequence of):  <b>ARTERIOVENOUS MALFORMATION OF BRAIN</b> Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 26, 1996</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>		31. Date filed (Month, Day, Year) <b>AUG 29 1996</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

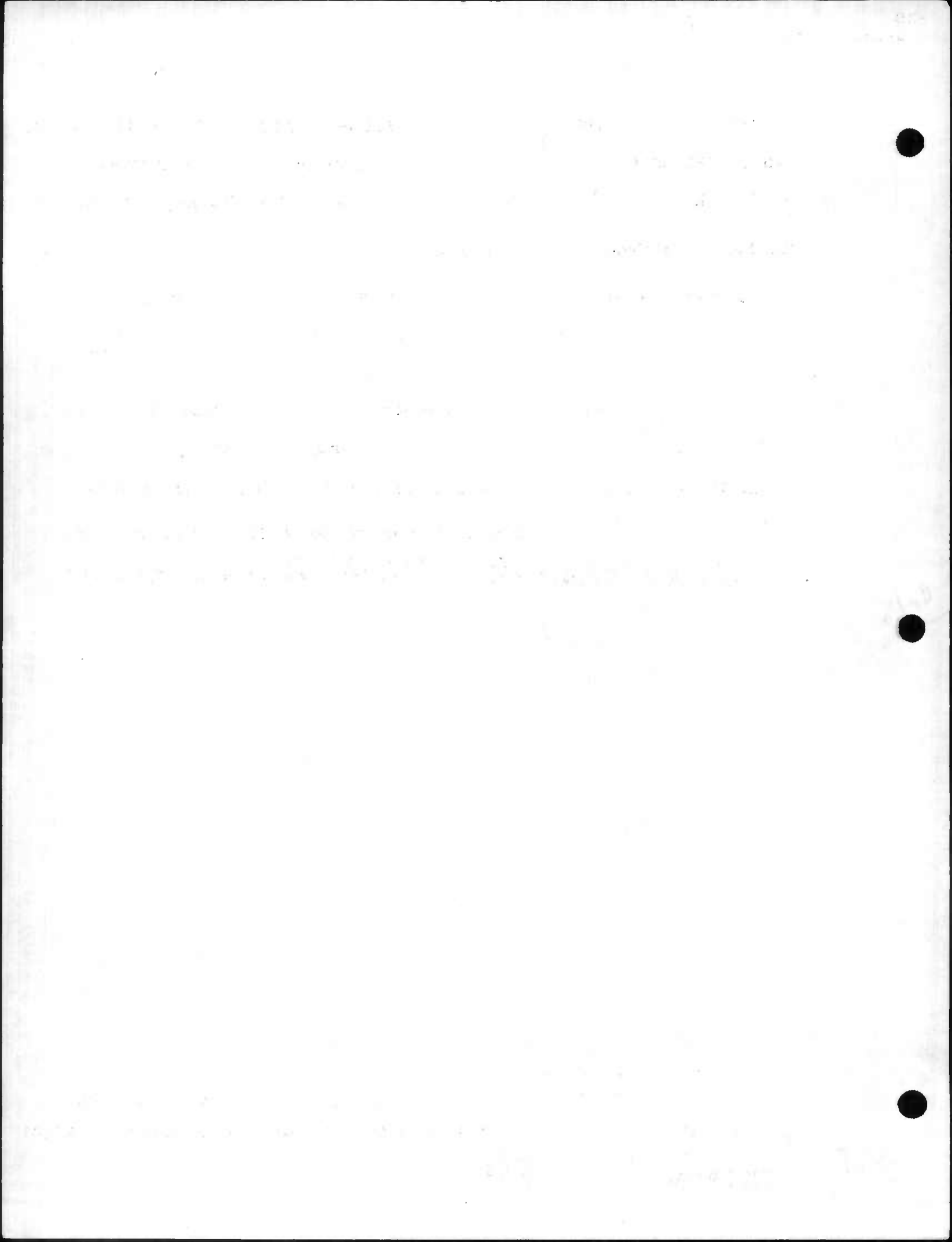
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25724

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARTHA F ROTHENBERG				2. Date of Death Month Day Year AUG. 24, 1996		3. Time of Death 3:15 AM		
	4a. Facility Name (If not institution, give street and number) MILFORD MANOR NURSING HOME				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 052-38-9269		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) JAN. 20, 1920		
	9. Birthplace (State or Foreign Country) NEW YORK		10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE		
Usual Residence of Decedent									
10e. Street and Number 3601 FORDS LA., APT. 822				10f. Zip Code 21215		10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DIETICIAN			16b. Kind of Business/Industry HOSPITAL		
17. Father's Name (First, Middle, Last) ISIDORE FRIED				18. Mother's Name (First, Middle, Maiden Surname) ELSIE RUBIN					
19e. Informant's Name/Relationship (Type, Print) JANE TORMAN (DAUG.)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11938 SENTINEL POINT RESTON, VA 20191					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) NEW MONTEFIORE (FIELD OF DAVID)		20c. Location - City or Town, State FARMINGDALE, NY			
21. Signature of Funeral Service Licensee Joy Alan Lewis				22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Non Hodgkins Lymphoma Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):									
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred					
28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier Irma Hunter Copeland MD				29c. License number D27034		29d. Date signed (Month, Day, Year) August 24, 1996			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Irma Hunter Copeland 530 Old Court Road suite 201 Randallstown MD 21133									
31. Date filed (Month, Day, Year) AUG 29 1996				32. Registrar's Signature James Davidson-Randall					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



96 25725

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>AMIGO RAYE</b>				2. DATE OF DEATH MONTH <b>August</b> DAY <b>26</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>6-40 P M</b>	
4. SOCIAL SECURITY NUMBER <b>150-07-9975</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>83</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Oct 14 1912</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Sandtown Winchester Nursing Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>Md</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>501 Dolphin Street</b>				10f. ZIP CODE <b>21217</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>6<sup>th</sup> grade</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Chef</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Hilton Hotel</b>			
17. FATHER'S NAME (First, Middle, Last) <b>unknown</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>unknown</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Misty Raye</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>403 N. Loudon Avenue, Baltimore, Maryland 21229</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		20c. DATE <b>9/1/96</b>		20d. LOCATION — City or Town, State <b>Baltimore, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Joseph H. Brown Jr. Funeral Home</b> <b>2140 N. Fulton Avenue, Baltimore, Maryland 21217</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Lung Carcinoma</b> DUE TO (OR AS A CONSEQUENCE OF): a. b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval between Onset and Death: <b>3 months</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>old myocardial infarct</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Amatun N. Naqem M.D.</b>				29c. LICENSE NUMBER <b>D15503</b>		29d. DATE SIGNED (Month, Day, Year) <b>August, 27, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>AMATUN N. NAQEM, 501 Dolphin Street, Balto, MD 21217</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 29 1996</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1950-1951



Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CATHERINE LENA RIDGE				2. Date of Death Month Day Year AUGUST 20, 1996		3. Time of Death 10:47 A.M.	
	4a. Facility Name (If not Institution, give street and number) HOMEWOOD NURSING HOME				4b. City, Town, or Location of Death WILLIAMSPORT		4c. County of Death WASHINGTON	
Funeral Director	5. Social Security Number 212-10-4299	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 101 Yrs.	8. Date of Birth (Month, Day, Year) MAY 12, 1895	9. Birthplace (State or Foreign Country) MARYLAND			
	Usual Residence of Decedent							
10a. State MD		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 935 ELMRIDGE AVENUE				10f. Zip Code 21229		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8TH GRADE College (1-4or 5+) College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PACKER		16b. Kind of Business/Industry B.V.D. & COMPANY		
17. Father's Name (First, Middle, Last) FREDERICK KOEHNLEIN JOHN GEORGE KOEHNLEIN				18. Mother's Name (First, Middle, Maiden Surname) KATHAR SCHOENHALS CATHERINE SCHOENHALS				
19a. Informant's Name/Relationship (Type, Print) CATHERINE BARKER (DAUGHTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 935 ELMRIDGE AVENUE - BALTIMORE, MD 21229				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY		Date 8/24/96		20c. Location - City or Town, State BALTIMORE, MD		
21. Signature of Funeral Service Licensee Jackie D. Shannon				22. Name and Address of Facility HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229				
23a. Pertinent to the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. CACHEXIA Due to (or as a consequence of): b. REFUSAL TO EAT Due to (or as a consequence of): c. EXTREME WEAKNESS Due to (or as a consequence of): d. CHRONIC PROGRESSIVE HEART FAILURE  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Approximate Interval Between Onset and Death 2 wks 2 wks MONTH YEARS								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia - Colon Cancer Atherosclerotic Cardiovascular Disease						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)				28e. Describe how injury occurred				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and Title of Certifier Medical Director						
29c. License number D17067		29d. Date signed (Month, Day, Year) 8/20/96						
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) STEPHEN E. MERZMAN, MD 747 MONTGOMERY AVE. HAGERSTOWN, 21742								
31. Date filed (Month, Day, Year) AUG 29 1996		32. Registrar's Signature William R. Riddell						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at 502a.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25727

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ALMA S. RUCKER

2. Date of Death

Month Day Year  
Aug - 25 - 1996

3. Time of Death

4:15 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Bon Secure Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

213-44-8086

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
10-17-24

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State  
MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2219 Elsinore Avenue

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Claims Examiner

16b. Kind of Business/Industry

Social Security

17. Father's Name (First, Middle, Last)

William J. Smith Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Evans

19a. Informant's Name/Relationship (Type, Print)

Karen Clifton - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2219 Elsinore Ave. Baltimore, MD 21216

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest

Date

8-30-96

20c. Location - City or Town, State

Owings Mills, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Albert P. Wylie Funeral Home P.A.  
638 N. Gilmer Street 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ANOXIC ENCEPHALOPATHY

Due to (or as a consequence of):

2 weeks

c. CEREBROVASCULAR ACCIDENT

Due to (or as a consequence of):

2 weeks

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PNEUMOTHORAX

SEPSIS

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D42510

29d. Date signed (Month, Day, Year)

Aug, 26th 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M-KASANTHAKUMAR, 821 N. EUTAW ST, SUITE 407, MD 21201

31. Date and Month, Day, Year

AUG 29 1996

32. Signature

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician  
/Medical  
Examiner

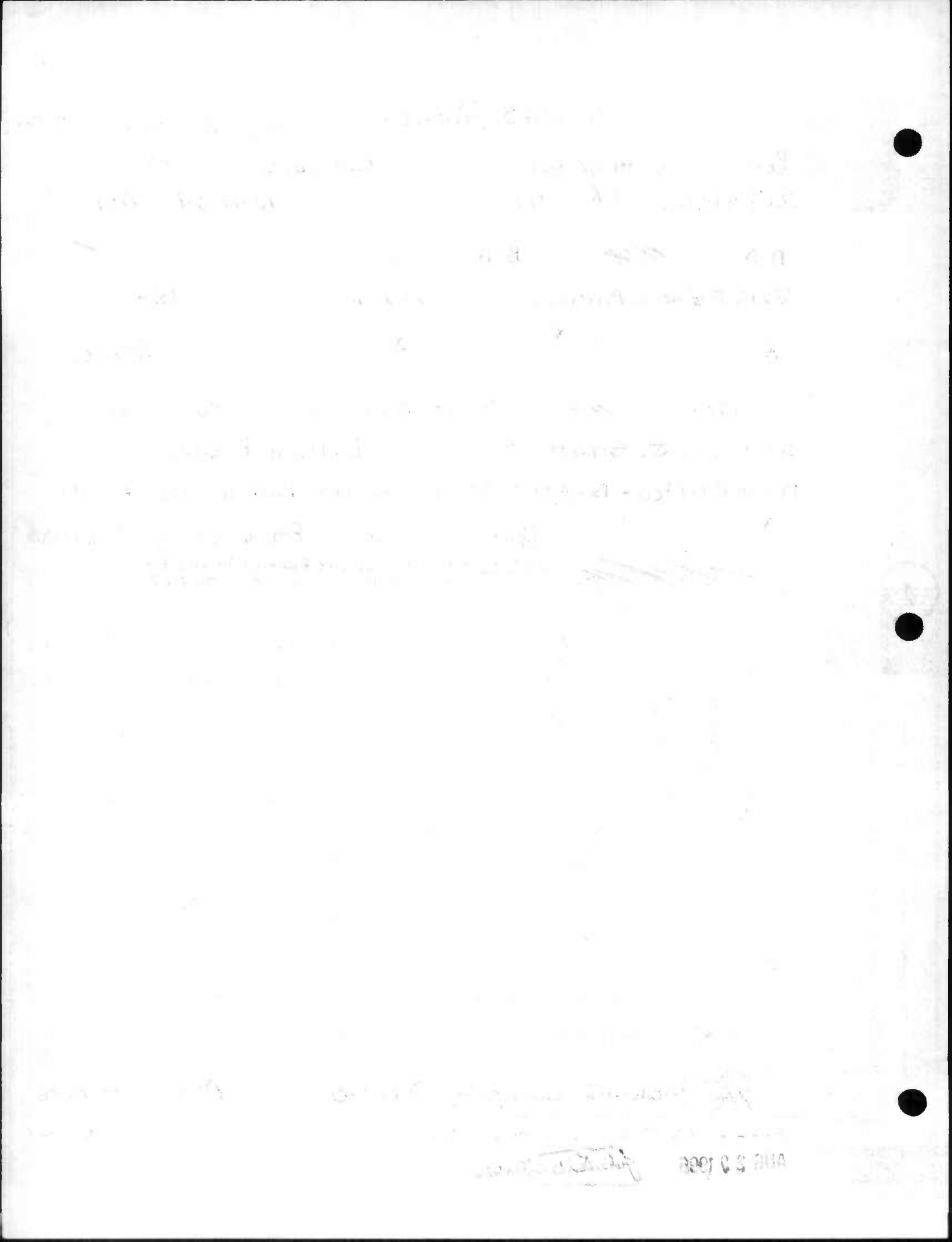
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25728

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FRANCIS SAUTER</b>				2. Date of Death Month <b>August</b> Day <b>28</b> Year <b>1996</b>		3. Time of Death <b>06:15 AM</b>	
	4a. Facility Name (If not Institution, give street and number) <b>NORTHWEST HOSPITAL CENTER</b>				4b. City, Town, or Location of Death <b>RANDALLSTOWN</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>217-18-8026</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept. 4, 1916</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Randallstown</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>5412 Old Court Road</b>				10f. Zip Code <b>21133</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Carpenter</b>		16b. Kind of Business/Industry <b>Building Construction</b>		
17. Father's Name (First, Middle, Last) <b>Gideon Nathaniel Sauter</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Laura Edna Schroeder</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Irma M. Smith/Niece</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1118 Old Westminster Pike Westminster, MD 21157</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc.</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>		
21. Signature of Funeral Service Licensee <b>Dawn F. McDonald</b>				22. Name and Address of Facility <b>Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. PULMONARY EDEMA</b> Due to (or as a consequence of): <b>b. ACUTE MYOCARDIAL INFARCTION</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>4 WEEKS</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>PNEUMONIA, RENAL INSUFFICIENCY</b> <b>COPD</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		
				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>C. Ravi MD</b>		29c. License number <b>D37333</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 28 1996</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>C. RAVI MD NHC BALTIMORE MD 21133</b>								
31. Date filed (Month, Day, Year) <b>AUG 29 1996</b>				32. Registrar's Signature <b>Gina Davidson-Randall</b>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25729

## Certificate of Death

Reg. No.

ITEM: 1, per M.D. G-738 8/29/96 reb

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ELEANOR STRETER</b>		2. Date of Death Month <b>8</b> Day <b>4</b> Year <b>96</b>		3. Time of Death <b>6:45 A.M.</b>
	4a. Facility Name (If not institution, give street and number) <b>North Charles Health Center</b>		4b. City, Town, or Location of Death <b>Balto</b>		4c. County of Death <b>WIA</b>
Funeral Director	5. Social Security Number <b>219-30-8434</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Aug 6, 1910</b>		9. Birthplace (State or Foreign Country) <b>VA.</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State <b>md</b>		10b. County <b>Balto</b>
	10c. City, Town or Location <b>Balto</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>2327 N. Charles st.</b>		10f. Zip Code <b>21218</b>		10g. Citizen of What Country? <b>U.S.A</b>
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th</b> College (1-4 or 5+) <b>NIA</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Domestic worker</b>
	17. Father's Name (First, Middle, Last) <b>Luther Williams</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Annie Layton</b>		19. Informant's Name/Relationship (Type, Print) <b>Dorothy Duke-Daughter</b>
	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1710 N. Mount St. Balto, md 21217</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>md National mem</b>
	20c. Location - City or Town, State <b>Laurel, md</b>		21. Signature of Funeral Service Licensee <b>Dorcia Elron</b>		22. Name and Address of Facility <b>March F. H. West 4300 Wabash Ave</b>
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>END STAGE RENAL DISEASE</b>				
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
Physician /Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
	29b. Signature and title of certifier <b>Jasneem Lakhani</b>		29c. License number <b>D28595</b>		29d. Date signed (Month, Day, Year) <b>8/5/96</b>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JASNEEM LAKHANI, 7220 PARK HEIGHTS AVE BALTO MD 21208</b>				
State Registrar	31. Date filed (Month, Day, Year) <b>AUG 29 1996</b>		32. Registrar's Signature <b>John H. ...</b>		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25730

Film G738 item 4,10b per FH 8-29-96 rja

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Mira Shumyatskaya

2. Date of Death  
Month Day Year

August 26 1996 4:27 pm

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

213352370

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
August 15, 1908

9. Birthplace (State or Foreign Country)

UKRAINE

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5715 Park Heights Avenue

10f. Zip Code

21215

10g. Citizen of What Country?

UKRAINE

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

PINCUS

18. Mother's Name (First, Middle, Maiden Surname)

SHUMYATSKAYA

GITTEL

ZISMAN

19a. Informant's Name/Relationship (Type, Print)

MR. BORIS BARMAN (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1 GREENWICH PLACE, APT. 1 BALTIMORE, MD 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARLINGTON CHIZUK AMUNO 8-28-1996- BALTIMORE, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*Michael B. Barmak*

22. Name and Address of Facility

Sol Levinson & Bros., Inc.  
8900 Reisterstown Road Pikesville, MD 21208

23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. myocardial ischemia

Due to (or as a consequence of):

b. critical aortic stenosis

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

one day

ten years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)

28b. Time of injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Carrie Adamson

29c. License number

D47869

29d. Date signed (Month, Day, Year)

August 26, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2401 West Belvedere, Baltimore, MD 21215

31. Date filed (Month, Day, Year)

AUG 29 1996

32. Registrar's Signature

*Julia Davidson-Randall*State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

16

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

96 25731

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GREG STUART SALZMAN</b>				2. Date of Death Month <b>AUGUST</b> Day <b>25</b> Year <b>1996</b>		3. Time of Death <b>2:30A.M.</b>					
	4a. Facility Name (If not institution, give street and number) <b>RT.140 EAST OF HUGHES SHOP ROAD</b>				4b. City, Town, or Location of Death <b>WESTMINSTER</b>		4c. County of Death <b>CARROLL COUNTY</b>					
Funeral Director	5. Social Security Number <b>213-60-5483</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>29</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>FEB. 17, 1967</b>					
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10a. State <b>MARYLAND</b>		10b. County <b>CARROLL</b>		10c. City, Town or Location <b>TANEYTOWN</b>					
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>2 WINDY HILLS DRIVE</b>		10f. Zip Code <b>21787</b>		10g. Citizen of What Country? <b>USA</b>					
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>					
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> Collage (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CARPENTER</b>		16b. Kind of Business/Industry <b>HOME CONSTRUCTION</b>							
	17. Father's Name (First, Middle, Last) <b>SHELDON SALZMAN</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>ROSE SAPPERSTEIN</b>		19a. Informant's Name/Relationship (Type, Print) <b>MRS. CRYSTAL SALZMAN (WIFE)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2 WINDY HILLS DRIVE TANEYTOWN, MD 21787</b>					
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ARLINGTON - CHIZUK AMUNO - 8-26-1996- BALTIMORE, MD</b>		20c. Location - City or Town, State		20d. Location - City or Town, State					
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Sol Levinson &amp; Bros., Inc. 8900 Reisterstown Road Pikesville, MD 21208</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Multiple Injuries</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  e. Due to (or as a consequence of):  f. Due to (or as a consequence of):  g. Due to (or as a consequence of):  h. Due to (or as a consequence of):		Approximate Interval Between Onset and Death					
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>ROAD</b>				27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			
State Registrar	28a. Date of Injury (Month, Day, Year) <b>8/25/96</b>				28b. Time of Injury <b>1324 M</b>				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	28d. Describe how injury occurred <b>motor vehicle accident</b>				28e. Location (Street and Number or Rural Route Number, City or Town, State) <b>RT 140 E. Hughes Shop Carroll Co. Md</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>RT 140 E. Hughes Shop Carroll Co. Md</b>			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 				29c. License number <b>O.C.M.E.</b>			
	29d. Date signed (Month, Day, Year) <b>AUGUST 25, 1996</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201</b>				31. Date filed (Month, Day, Year) <b>AUG 29 1996</b>			
32. Registrar's Signature 												

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State of Maryland / Department of Health and Mental Hygiene

96 25732

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DORSEY, STATION

2. Date of Death  
Month Day Year  
AUG 25 19963. Time of Death  
00:30a

4a. Facility Name (If not institution, give street and number)

30 ST. AGNES HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

n/a

Funeral  
Director

5. Social Security Number

238-18-0587

6. Sex

10M 20F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

FEB. 16, 1918

9. Birthplace (State or Foreign Country)

N. CAROLINA

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

10 Yes 20 No

10e. Street and Number

3040 EDMONDSON AVENUE

10f. Zip Code

21223

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

10 Navar Married 20 Married

30 Widowed 40 Divorced

12. Was Decedent Ever in U.S.

10 Yes 20 No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 20 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6 th

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

LABORER

16b. Kind of Business/Industry

LONGSHOREMAN

17. Father's Name (First, Middle, Last)

MOSES STATION

18. Mother's Name (First, Middle, Maiden Surname)

CORA

19a. Informant's Name/Relationship (Type, Print)

MARGARET JORDON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3040 EDMONDSON AVE, BALTIMORE, MD 21223

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State

40 Donation 50 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARBUTUS MEMORIAL PARK 8-30

Date

20c. Location - City or Town, State

ARBUTUS, MD

21. Signature of Funeral Service Licensee

D. S. HARRIS

22. Name and Address of Facility

WM. C. MARCH FH.-1101 E. NORTH AVENUE

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

CARDIOMYOPATHY

Due to (or as a consequence of):

Approximate interval Between Onset and Death

8 YRS

b.

RESPIRATORY ARREST

Due to (or as a consequence of):

15 MIN

c.

SEPSIS

Due to (or as a consequence of):

1 DAY

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy performed?

10 Yes 20 No

24b. Were autopsy findings available prior to completion of cause of death?

10 Yes 20 No

25. Was case referred to medical examiner?

10 Yes 20 No

Hospital:

10 Inpatient 20 ER/Outpatient 30 DOA

26. Place of Death (Check only one)

Other: 40 Nursing Home 50 Residence 60 Other (Specify)

27. Manner of Death

10 Natural 50 Pending Investigation

20 Accident 60 Could not be determined

30 Suicide 40 Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

10 Yes 20 No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mamatha S. Ananth PGM, RESIDENT PO 8417

29c. License number

29d. Date signed (Month, Day, Year)

AUG 25, 1996

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

MAMATHA-S. ANANTH. 900 CATON AVE, ST AGNES HOSPITAL, BALTIMORE MD 21229

31. Date filed (Month, Day, Year)

AUG 29 1996

32. Registrar's Signature

Wilson-Pandell

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 902-611-1000.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25733

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BENJAMIN SIMS

2. Date of Death

AUG. 22, 1996

3. Time of Death

2:50 pm

4a. Facility Name (If not institution, give street and number)

201 PACKARD AVENUE apt.1

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL CO.

Funeral  
Director

5. Social Security Number

225-44-9440

6. Sex

XXM 2□F

7. Age (In yrs. last birthday)

60

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JAN. 10, 1936

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MD

10b. County

ANNE ARUNDEL CO.

10c. City, Town or Location

GLEN BURNIE

10d. Inside City Limits

1□Yes 2□No

10e. Street and Number

201 PACKARD AVENUE apt.1

10f. Zip Code

21061

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

XX  
1□Never Married 2□Married  
3□Widowed 4□Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1□Yes 2□No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□Yes 2XXNo Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LABORER

16b. Kind of Business/Industry

CONSTRUCTION

17. Father's Name (First, Middle, Last)

RUBEN JOHNSON

18. Mother's Name (First, Middle, Maiden Surname)

ELVIN SIMS

19a. Informant's Name/Relationship (Type, Print)

SARAH A. HOLMES

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7070 TIMBERFIELD PLACE, MARYLAND 21126

20a. Method of Disposition

1XBurial 2□Cremation 3□Removal from State  
4□Donation 5□Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. ZION CEMETERY

Date

8-27

20c. Location - City or Town, State

LANDSDOWNE, MD

21. Signature of Funeral Service Licensee

Wm. C. Marchfh.

22. Name and Address of Facility

WM. C. MARCHFH.-1101 E. NORTH AVENUE

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute myocardial infarction  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

unknown

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Hypertension (probable)  
Due to (or as a consequence of):

unknown

c. Chronic Renal Failure  
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Cor Pulmonale  
Atherosclerosis

23b. Did tobacco use contribute to the cause of death?

1XYes 2□No 3□Probably 4□Unknown

24a. Was an autopsy performed?

1□Yes 2XNo

24b. Were autopsy findings available prior to completion of cause of death?

1□Yes 2XNo

25. Was case referred to medical examiner?

1□Yes 2□No

26. Place of Death (Check only one)

Hospital:

1□Inpatient

2□ER/Outpatient

3□DOA

Other:

4□Nursing Home

5XResidence

6□Other (Specify)

27. Manner of Death

1□Natural  
2□Accident  
3□Suicide  
4□Homicide5□Pending investigation  
6□Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1□Yes 2□No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2□Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Bayunna Shabazz MD

29c. License number

D24592

29d. Date signed (Month, Day, Year)

Aug. 23, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Bayunna Shabazz MD,  
1600 Crain Hwy Glen Burnie

31. Date filed (Month, Day, Year)

AUG 29 1996

32. Registrar's Signature

A. R. Rindson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





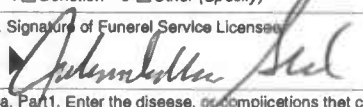
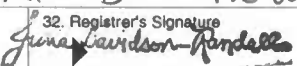
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25734

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MATTHEW THOMAS STAMER</b>				2. Date of Death Month <b>AUG</b> Day <b>27</b> Year <b>96</b>		3. Time of Death <b>4.35 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Howard County General Hospital</b>				4b. City, Town, or Location of Death <b>Columbia</b>		4c. County of Death <b>Howard County</b>	
Funeral Director	5. Social Security Number <b>pending</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>42</b> Yrs.	If Under 1 Year Months <b>42</b> Days	If Under 24 Hrs. Hours <b>42</b> Min.	8. Date of Birth (Month, Day, Year) <b>July 15, 1996</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Carroll County</b>		10c. City, Town or Location <b>Eldersburg</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10a. Street and Number <b>5170 Bartholow Road</b>				10f. Zip Code <b>21784</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>n/a</b> College (1-4 or 5+) <b>n/a</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>n/a</b>			16b. Kind of Business/Industry <b>n/a</b>	
17. Father's Name (First, Middle, Last) <b>Timothy A. Stamer</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sharon L. Yarko</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Mr. Timothy Stamer/father</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5170 Bartholow Road, Eldersburg, MD 21784</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Columbia Memorial Park</b>		Date <b>8-31-96</b>		20c. Location - City or Town, State <b>Columbia, MD</b>		
21. Signature of Funeral Service Licensee  <b>M00535</b>				22. Name and Address of Facility <b>Slack Funeral Home, P.A. Ellicott City, Maryland 21043</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. SEPTIC SHOCK</b> Due to (or as a consequence of): <b>b. GROUP B STREPTOCOCCUS SEPTICEMIA</b> Due to (or as a consequence of): <b>c. GROUP B STREPTOCOCCUS MENINGITIS</b> Due to (or as a consequence of): <b>d. ENCEPHALOPATHY</b>								Approximate Interval Between Onset and Death <b>MIN</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>PREMATURITY</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Bharti Razdan MD</b>		29c. License number <b>D 47620</b>		29d. Date signed (Month, Day, Year) <b>AUG 27 '96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>BHARTI RAZDAN, MD HOWARD COUNTY GENERAL HOSPITAL</b>								
31. Date filed (Month, Day, Year) <b>AUG 29 1996</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



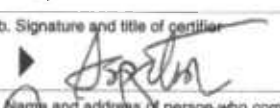
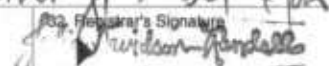
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25735

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) <i>Susie F. Stinchcomb</i>						2. Date of Death Month <i>August</i> Day <i>26</i> Year <i>1996</i>		3. Time of Death <i>11:15 P.M.</i>		
	4a. Facility Name (If not institution, give street and number) <i>North Arundel Hospital</i>						4b. City, Town, or Location of Death <i>Glen Burnie</i>		4c. County of Death <i>Anne Arundel</i>		
Funeral Director	5. Social Security Number <i>214-30-3091</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>65</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>08-03-1931</i>		9. Birthplace (State or Foreign Country) <i>MARYLAND</i>		
	Usual Residence of Decedent										
10a. State <i>MARYLAND ANNE ARUNDEL</i>			10b. County <i>GLEN BURNIE</i>		10c. City, Town or Location <i>21060</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10a. Street and Number <i>17 QUEEN ANNE ROAD</i>			10f. Zip Code <i>21060</i>			10g. Citizen of What Country? <i>U.S.A.</i>					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>WHITE</i>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>9</i> College (1-4or 5+) <i>N/A</i>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>HOMEMAKER</i>			16b. Kind of Business/Industry <i>OWN HOME</i>					
17. Father's Name (First, Middle, Last) <i>ERNEST STINCHCOMB</i>						18. Mother's Name (First, Middle, Maiden Surname) <i>CATHERINE BURLINE</i>					
19a. Informant's Name/Relationship (Type, Print) <i>KELLY M. STINCHCOMB (DAUGHTER-IN-LAW)</i>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>17 QUEEN ANNE ROAD, GLEN BURNIE, MARYLAND 21060</i>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>GLEN HAVEN MEMORIAL PARK</i>			Date <i>8/29/96</i>		20c. Location - City or Town, State <i>GLEN BURNIE, MD.</i>			
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <i>SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</i>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  e. <i>CONGESTIVE HEART FAILURE</i> Due to (or as a consequence of): b. <i>ISCHEMIC CARDIOMYOPATHY</i> Due to (or as a consequence of): c. <i>VENTRICULAR FIBRILLATION</i> Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>DIABETES MELLITUS</i>										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier  MD								
			29c. License number <i>D43977</i>		29d. Date signed (Month, Day, Year) <i>August 26 1996</i>						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Cheryl Overmyer: 301 HORTON DRIVE GLEN BURNIE MD 21061</i>											
31. Date filed (Month, Day, Year) <i>AUG 29 1996</i>			32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

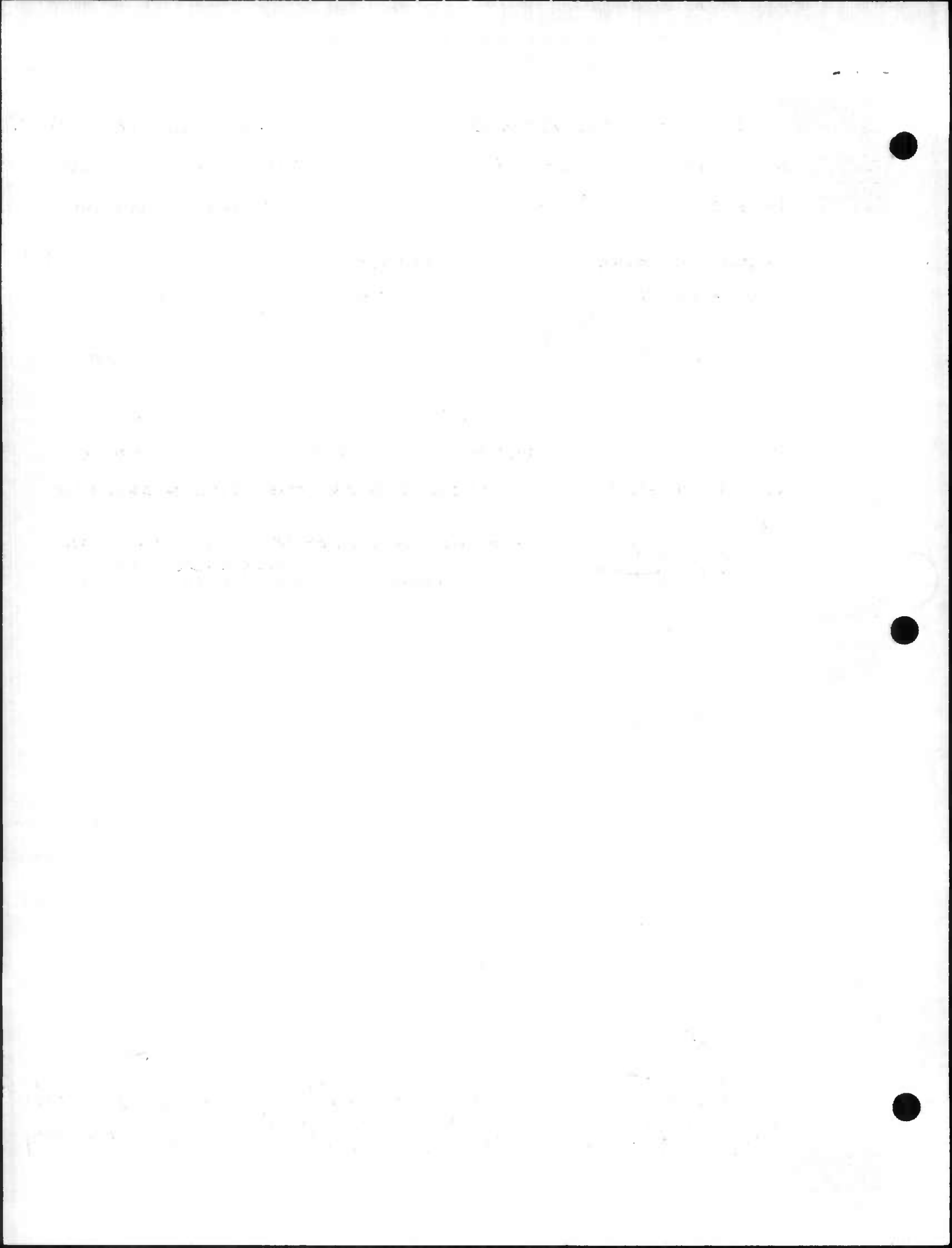
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



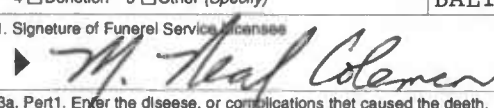
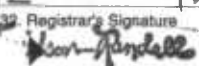
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25736

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Walter C. Sellman, Sr.</b>						2. Date of Death Month <b>August</b> Day <b>26</b> Year <b>1996</b>		3. Time of Death <b>5:10 P.m.</b>		
	4a. Facility Name (If not institution, give street and number) <b>North Arundel Hospital</b>						4b. City, Town, or Location of Death <b>Glen Burnie</b>		4c. County of Death <b>Anne Arundel</b>		
Funeral Director	5. Social Security Number <b>212-30-2606</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>62</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>OCT 14, 1933</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		
	Usual Residence of Decedent										
10a. State <b>MD</b>			10b. County <b>ANNE ARUNDEL</b>			10c. City, Town or Location <b>GLEN BURNIE</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>106 HERBERT COURT</b>						10f. Zip Code <b>21060</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>KOREAN</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11TH GRADE</b> College (1-4or 5+) <b>COLLEGE (1-4or 5+)</b>						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PRODUCE INSPECTOR</b>			16b. Kind of Business/Industry <b>GIANT FOODS</b>		
17. Father's Name (First, Middle, Last) <b>LEONARD RUDOLPH SELLMAN</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>EDNA MARGUERITE NAGEL</b>					
19a. Informant's Name/Relationship (Type, Print) <b>BEVERLY J. SELLMAN (WIFE)</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>106 HERBERT COURT - GLEN BURNIE, MD 21060</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BALTO NAT'L CEMETERY</b>		Date <b>8/30/96</b>		20c. Location - City or Town, State <b>BALTIMORE</b>			
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>ANOLIC ENCEPHALOPATHY</b> Due to (or as a consequence of): b. <b>SUDDEN CARDIAC DEATH</b> Due to (or as a consequence of): c. <b>CORONARY ARTERY DISEASE</b> Due to (or as a consequence of): d.  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier  <b>MD</b>				29c. License number <b>D43977</b>		29d. Date signed (Month, Day, Year) <b>August 26 1996</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Chapman Okeimij, 301 HOSPITAL DRIVE, Glen Burnie MD 21061</b>											
31. Date filed (Month, Day, Year) <b>AUG 29 1996</b>				32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

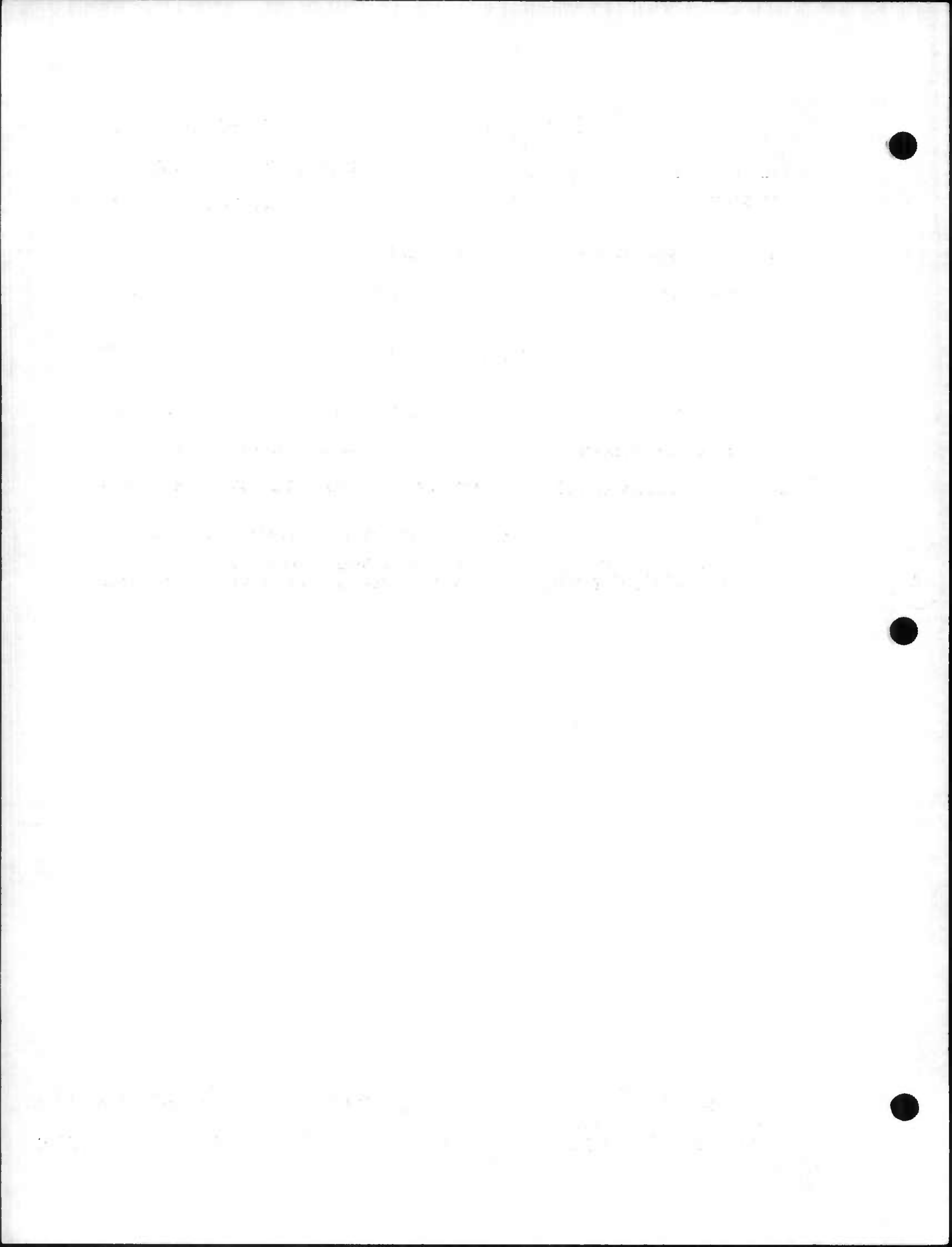
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



9/5/96 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25737

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Joseph Smith JR.				2. Date of Death Month Day Year August 3, 1996		3. Time of Death 12:17 p.m.	
	4a. Facility Name (If not institution, give street and number) Washington County Hospital				4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington County	
Funeral Director	5. Social Security Number 214-78-3669		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 23 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JULY 5, 1973	9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE CITY		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 1417 N. MILTON AVENUE				10f. Zip Code 21213		10g. Citizen of What Country? USA	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th GRADE		College (1-4 or 5+) UNEMPLOYED		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) UNEMPLOYED		16b. Kind of Business/Industry N/A	
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) JOHN JOSEPH SMITH JR.				18. Mother's Name (First, Middle, Maiden Surname) LELIA SMITH			
	19a. Informant's Name/Relationship (Type, Print) LELIA SMITH				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1815 PRESSTMAN ST., BALTIMORE, MD. 21217			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY		Date 8-8-96		20c. Location - City or Town, State BALTIMORE, MARYLAND	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 2140 N. FULTON AVE., BALTIMORE, MD. 21217					
Physician /Medical Examiner	23a. Part I. Name of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	Immediate Cause (Final disease or condition resulting in death)		a. Subdural hematoma Due to (or as a consequence of):					Approximate Interval Between Onset and Death ~ 18 hours
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Renal failure Due to (or as a consequence of):					Years
			c. Malignant hypertension Due to (or as a consequence of):					~ 3 days
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number D0050813		29d. Date signed (Month, Day, Year) 8/3/96	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neil P. O'Malley 11110 Medical Campus Rd Hagerstown, MD 21740							
	31. Date filed (Month, Day, Year) AUG 29 1996							
	32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene 96 25738

Film G738 items 12 8-29-96 rja

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Johnny L. Thomas

2. Date of Death

August 21 1996

3. Time of Death

3:40 AM

4a. Facility Name (If not institution, give street and number)

BAYVIEW HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

n/a

5. Social Security Number

241-30-4567

8. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JUN. 6, 1923

9. Birthplace (State or Foreign Country)

N. CAROLINA

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1725

DARLEY AVENUE

10f. Zip Code

21213

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

XX  
1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

XX Yes ~~2000~~ - dates unk.  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

BETHLEHEM LABORER

16b. Kind of Business/Industry

STEEL CORP.

17. Father's Name (First, Middle, Last)

TURNER THOMAS

18. Mother's Name (First, Middle, Maiden Surname)

MATTIE FLEETWOOD

19a. Informant's Name/Relationship (Type, Print)

DIANE V. THOMAS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1725 DARLEY AVE, BALTIMORE, MD 21213

20a. Method of Disposition

XX Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST VA CEM.

Date

20c. Location - City or Town, State

8-026 OWINGS MILLS

21. Signature of Funeral Service Licensee

James B. Harris

22. Name and Address of Facility

WM. C. MARCHFH.-1101 E. NORTH AVE.

23a. Pertinent enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Aspiration Pneumonia

Due to (or as a consequence of):

1 week

c. Multiple Pressure Ulcers

Due to (or as a consequence of):

5 months

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Insulin Dependent Diabetes, Coronary artery disease,

Anemia, Gastrointestinal Bleed, right carotid

artery disease, Myocardial Infarction, Malnutrition

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 8 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Richard Bennett MD

29c. License number

DR8461

29d. Date signed (Month, Day, Year)

8.21.96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richard Bennett MD 5505 Hopkins Bayview Balto, MD 21224

31. Date filed (Month, Day, Year)

AUG 29 1996

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

96 25739

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Elizabeth Thompson</b>		2. Date of Death Month <b>August</b> Day <b>22</b> Year <b>1996</b>		3. Time of Death <b>10:23</b>
	4a. Facility Name (If not institution, give street and number) <b>Northwest Hospital</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>Baltimore</b>
Funeral Director	5. Social Security Number <b>417-40-0778</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>64</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>JUL. 21, 1932</b>	
	9. Birthplace (State or Foreign Country) <b>HOUSTON CO., AL</b>		10a. State <b>MD</b>		
To Be Completed by Funeral Director	10b. County <b>n/a</b>		10c. City, Town or Location <b>BALTIMORE CO.</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>huntcliff drive</b>		10f. Zip Code <b>21117</b>		10g. Citizen of What Country? <b>UNITED STATES</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 th</b> College (1-4 or 5+) <b>-</b>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>NURSES ASSISTANT</b>		16b. Kind of Business/Industry <b>MEDICAL</b>		
	17. Father's Name (First, Middle, Last) <b>LEE CHAMBERS</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>LAURA M. PORTER</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>CYNTHIA THOMPSON</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>28 DOWLING CT., BALTIMORE C, MD</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>VOSHALL MEMORIAL GARDENS 8-27</b>		20c. Location - City or Town, State <b>DUNDALK, MARYLAND</b>
	21. Signature of Funeral Service Licensee <b>[Signature]</b>		22. Name and Address of Facility <b>WM. C. MARCH FH.-1101 E. NORTH AVENUE</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>MYOCARDIAL INFARCTION (POSSIBLE 5 min CAUSE)</b> <b>CORONARY ARTERY OCCLUSION</b> <b>1 min</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>{</b> <b>DIA BETES MELLITUS</b> <b>ARTERIO SCLEROSIS</b>		Approximate Interval Between Onset and Death		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DIA BETES MELLITUS</b> <b>ARTERIO SCLEROSIS</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>P15140</b>	
29d. Date signed (Month, Day, Year) <b>8/22/96</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>1 - SUMMERS, MD 6210 1 KENNEDY AVE, BALTO, MD 21215</b>			
31. Date filed (Month, Day, Year) <b>AUG 29 1996</b>		32. Registrar's Signature <b>[Signature]</b>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,




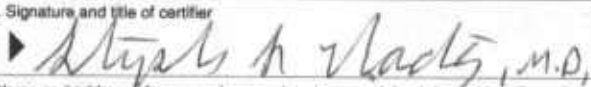
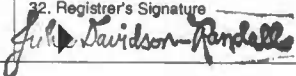
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25740

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WILLIE MAE THOMPSON</b>				2. Date of Death Month <b>AUG.</b> Day <b>23</b> , Year <b>1996</b>		3. Time of Death <b>1954 PM</b>	
	4e. Facility Name (If not institution, give street and number) <b>2803 REMINGTON AVENUE</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>n/a</b>	
Funeral Director	5. Social Security Number <b>237-66-8714</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>53</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>APR. 8, 1943</b>		9. Birthplace (State or Foreign Country) <b>N. CAROLINA</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>m/a</b>		10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>2803 REMINGTON AVENUE</b>			10f. Zip Code <b>21211</b>		10g. Citizen of What Country? <b>UNITED STATES</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year of Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 th</b> Collage (1-4 or 5+) <b>-</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>GUARD (CROSSING)</b>			18b. Kind of Business/Industry <b>BALTIMORE CITY SCHOOLS</b>		
	17. Father's Name (First, Middle, Last) <b>LEROY JENNINGS</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>JOSEPHINE COLE</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>DIANNE R. STEWART</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1314 GITTINGS AVENUE, BALTIMORE, MD 21239</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>WESTERN STAR CEMETERY</b>		Date <b>8-28</b>		20c. Location - City or Town, State <b>CATONSVILLE, MD</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>WM. C. MARCH FH.-1101 E. NORTH AVENUE</b>			
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>e. Hypertensive Arteriosclerotic Cardiovascular Disease</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <b>INSPECTION</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <b>ASTHMA</b>								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>AUG. 23, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Stephen S. Radentz, M.D. 111 Penn Street, Baltimore, Maryland 21201</b>								
31. Date filed (Month, Day, Year) <b>AUG 29 1996</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

10

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25741

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BARBARA ANN TOWNSEND				2. Date of Death Month Day Year Aug. 24, 1996		3. Time of Death 12:50A	
	4a. Facility Name (If not Institution, give street and number) STELLA MARIS AT MERCY				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 218-76-5544		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 40 Yrs.		8. Date of Birth (Month, Day, Year) AUG. 14, 1956	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MARYLAND		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE CITY	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 1219 N. DALLAS STREET		10f. Zip Code 21213		10g. Citizen of What Country? USA.	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) GED		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOME MAKER		16b. Kind of Business/Industry OWN HOME		17. Father's Name (First, Middle, Last) UNKNOWN	
	18. Mother's Name (First, Middle, Maiden Surname) CLARA BEE TOWNSEND		19a. Informant's Name/Relationship (Type, Print) LOLITA FOWLES		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1219 N. DALLAS STREET, BALTIMORE MD. 21213		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
Physician /Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEMETERY		20c. Location - City or Town, State BALTIMORE, MD.		21. Signature of Funeral Service Licensee [Signature]		22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO, MD. 21217	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC BREAST CANCER Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 4 years		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
Medical Certification: To Be Completed by Physician/Medical Examiner	24b. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24c. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) HOSPICE	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier [Signature]	
	29c. License number D40480		29d. Date signed (Month, Day, Year) August 25, 1996		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FERNANDO J. FERRA, MD BALTO., MD 21206		31. Data filed (Month, Day, Year) AUG 29 1996	
31. Registrar's Signature Julia Robinson-Randall								





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25742

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Everette

Williams

2. Date of Death

Month Day Year  
08-26-96

3. Time of Death

8:40 AM

4a. Facility Name (If not institution, give street and number)

Alice Manor N.H.

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

n/a

Funeral  
Director

5. Social Security Number

216-03-6098

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 7, 1911

9. Birthplace (State or Foreign Country)

Zebulon, NC

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2095 ROCKROSE AVENUE

10f. Zip Code

21211

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

☐ Never Married ☐ Married  
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
unknown

College (1-4 or 5+)

16e. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

MAINTENANCE

16b. Kind of Business/Industry

SINAI HOSPITAL

17. Father's Name (First, Middle, Last)

unk.

18. Mother's Name (First, Middle, Maiden Surname)

LILLIE WILLIAMS

19e. Informant's Name/Relationship (Type, Print)

RUTH JEAN DAVIS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6207 WINNER AVENUE, BALTIMORE, MD 21215

20e. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

ARBUTUS MEMORIAL PARK

Date

8-30

20c. Location - City or Town, State

ARBUTUS, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

WM. C. MARCHFH.-1101 E. NORTH AVENUE

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Due to (or as a consequence of):

cardio pulmonary arrest

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

ca. of lung with metastasis

c. Due to (or as a consequence of):

ca. of prostate

d. Due to (or as a consequence of):

STP cur

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24e. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?  
☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury of  
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-20146

29d. Date signed (Month, Day, Year)

8/27/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H. Devadoss M.D.

Alice Manor N.H., Balto. MD

31. Date filed (Month, Day, Year)

AUG 29 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25743

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Antoinette Cecelia Willis

2. Date of Death

Aug. 28 1996

3. Time of Death

4:00 AM

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

213-52-3636

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

47 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 6, 1948

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5066 Clifton Ave.

10f. Zip Code

21207

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Negro

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Thermon P. Gross

18. Mother's Name (First, Middle, Maiden Surname)

Victorine Freeman

19a. Informant's Name/Relationship (Type, Print)

Mrs. Victorine Hall

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1505 N. Hilton St. Balto. Md. 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus

Date

9/3/96

20c. Location - City or Town, State

Balto. Co. Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home  
2222 W. North Ave. Balto. Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CIRRHOSIS OF THE LIVER

20 MONTHS

Due to (or as a consequence of):

b. HEPATITIS C

12 MONTHS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Arjun Meera M.D.

29c. License number

P-09519

29d. Date signed (Month, Day, Year)

08/28/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Tarun MeHRAMP, 900 Catow Ave Baltimore, MD 21229

31. Date filed (Month, Day, Year)

AUG 29 1996

32. Registrar's Signature

John Anderson

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25744

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Dora Mae White</b>				2. Date of Death Month <b>August</b> Day <b>27</b> Year <b>1996</b>				3. Time of Death <b>6:30 am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Johns Hopkin Bayview Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>216-34-1341</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>71</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>MAY 21, 1925</b>		9. Birthplace (State or Foreign Country) <b>N. Carolina</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number <b>1818 Harford Avenue</b>				10f. Zip Code <b>21213</b>		10g. Citizen of What Country? <b>United States</b>			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7th</b> Collage (1-4 or 5+) <b>-</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Domestic</b>			16b. Kind of Business/Industry <b>Someone Else's Home</b>		
	17. Father's Name (First, Middle, Last) <b>Robert Clark</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Dora Clark</b>					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Evelyn Wooden</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1818 Harford Avenue, Baltimore, Maryland 21213</b>					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>VOSHELL MEMORIAL GARDENS 8-30 DUNDALK, MD</b>		20c. Location - City or Town, State			
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>March Funeral Home 1101 E. North Avenue, Baltimore, MD 21202</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  immediate Cause (Final disease or condition resulting in death) <b>a. Septic Shock</b> <b>b. Intra-abdominal infection</b> <b>c. Toxic reaction</b> <b>d.</b>									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
State Registrar	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined									
28a. Date of Injury (Month, Day, Year)										
28b. Time of Injury <b>M</b>										
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
28d. Describe how injury occurred										
28e. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>208358</b>			29d. Date signed (Month, Day, Year) <b>8/28/96</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>GPA cito K. PATRICKO 8903 HARFORD ROAD BALT. MD 21234</b>										
31. Date filed (Month, Day, Year) <b>AUG 29 1996</b>										
32. Registrar's Signature <i>[Signature]</i>										



96 25745

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Warren Wingate</i>				2. DATE OF DEATH MONTH <i>August</i> DAY <i>25</i> YEAR <i>1996</i>		3. TIME OF DEATH <i>5:10 P.M.</i>	
4. SOCIAL SECURITY NUMBER <i>216-16-6404</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>72</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Feb. 10, 1924</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Fredrick Villa Nursing Center</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Catonsville</i>	
9c. COUNTY OF DEATH <i>Baltimore</i>				10a. STATE <i>Maryland</i>		10b. COUNTY <i>Baltimore</i>	
10c. CITY, TOWN OR LOCATION <i>Arbutus</i>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <i>5423 Council Street</i>	
10f. ZIP CODE <i>21227</i>				10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>white</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>warehouseman</i>		16b. KIND OF BUSINESS/INDUSTRY <i>farm equipment</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Norman R. Wingate</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Ora V. Dayton</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Lorna Wingate, daughter</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>7 Trotting Horse Court Catonsville, MD 21228</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Loudon Park Cemetery 8/29/96 Baltimore, Maryland</i>		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>Ambrose Funeral Home, Inc. Arbutus 1328 Sulphur Spring Road 21227</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Respiratory failure</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Sepsis</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { <i>Septic arthritis</i> Approximate Interval Between Onset and Death <i>11 days</i> <i>11 days</i> <i>11 days</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <i>028236</i>		29d. DATE SIGNED (Month, Day, Year) <i>8/27/96</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) <i>Devian S St Martin 541 Old Frederick Rd Balt, MD 21229</i>							
31. DATE FILED (Month, Day, Year) <i>AUG 29 1996</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit form. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Amended item #18, g-739, 9/4/96emh per fh  
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

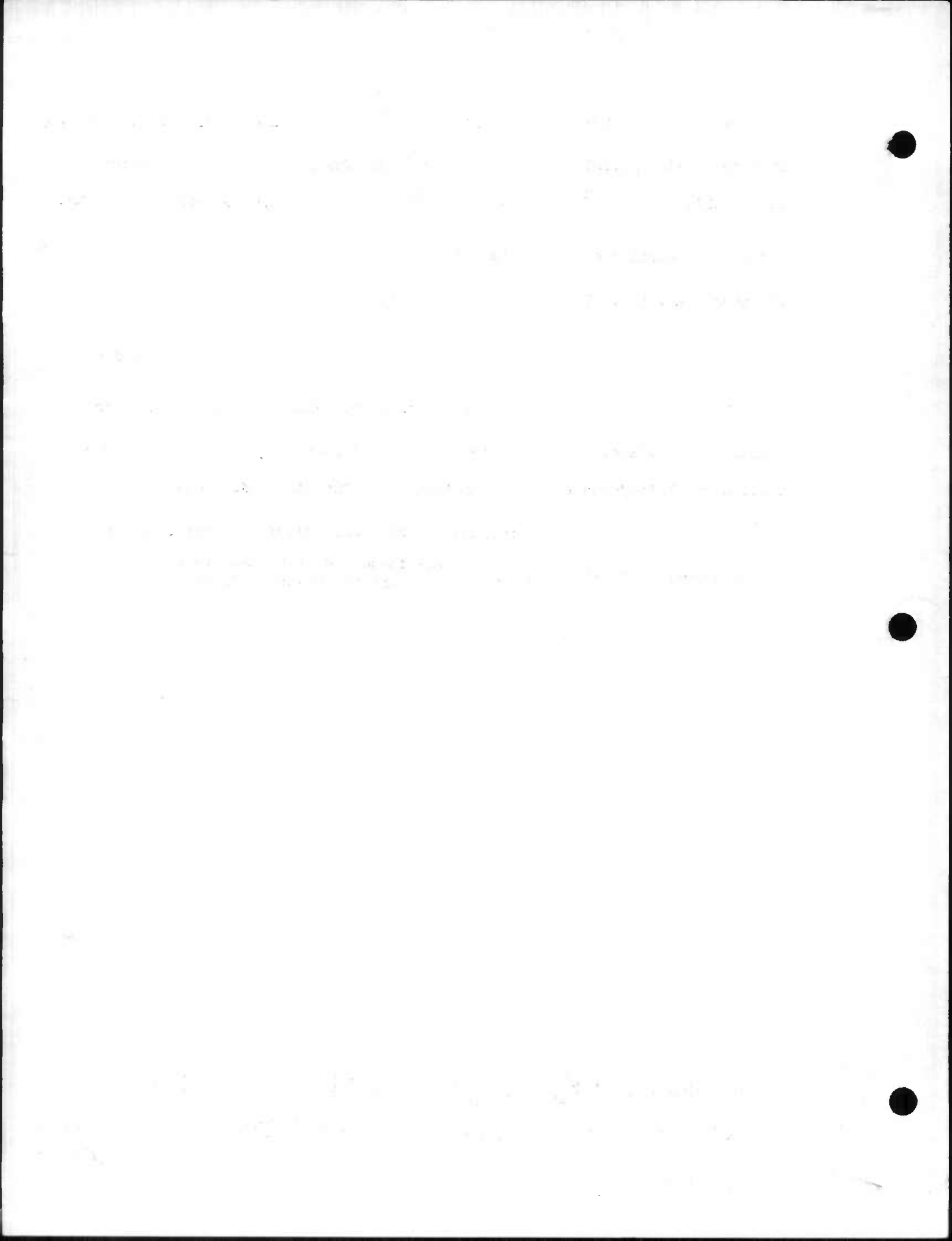
State of Maryland / Department of Health and Mental Hygiene

96 25746

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROSE ANN YAFFE			2. Date of Death Month Aug. Day 26, Year 1996		3. Time of Death 10:04 AM	
	4a. Facility Name (If not institution, give street and number) 20 Dunvale Rd. Apt. 207			4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 220-01-6114		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	8. Date of Birth (Month, Day, Year) Nov. 5, 1920	9. Birthplace (State or Foreign Country) Md.	
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State Md.		10b. County Baltimore		10c. City, Town or Location Towson		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 20 Dunvale Rd. Apt. 207			10f. Zip Code 21204		10g. Citizen of What Country? USA	
To Be Completed by Physician/Medical Examiner	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pharmaceutical Technician		16b. Kind of Business/Industry Morgan & Millard		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Daniel Edward Burgie			18. Mother's Name Bridget Agnes Kelly Ann Yaffe			
	19a. Informant's Name/Relationship (Type, Print) Barbara Ann Yaffe/Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Talbott Ave. Timonium, Md. 21093			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Moreland Memorial Park 8/29/96		20c. Location - City or Town, State Baltimore, Md.		Approximate Interval Between Onset and Death
	21. Signature of Funeral Service Licensee Wallace S. Brooks, Jr.		22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204				
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory Failure Due to (or as a consequence of): b. severe advanced COPD Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Possible cardiac arrhythmias						
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined						
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day, Year)						
	28b. Time of Injury M						
To Be Completed by Physician/Medical Examiner	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
	28d. Describe how Injury occurred						
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
	29b. Signature and title of certifier George Reden MD						
To Be Completed by Physician/Medical Examiner	29c. License number D12732						
	29d. Date signed (Month, Day, Year) 8/27/96						
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEORGE REDEN MD 515 FAIRMOUNT AVE - TOWSON						
	31. Data filed (Month, Day, Year) AUG 29 1996						
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature J. A. [Signature]						
	33. Date 8/28/96						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25747

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>LEONIE L. Guskid</i>						2. Date of Death Month <i>August</i> Day <i>26</i> Year <i>1986</i>		3. Time of Death <i>3:40 PM</i>	
	4a. Facility Name (If not Institution, give street and number) <i>Vantage House</i>						4b. City, Town, or Location of Death <i>Columbia</i>		4c. County of Death <i>Howard</i>	
Funeral Director	5. Social Security Number <i>191367892</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>83</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>APR. 23, 1913</i>		9. Birthplace (State or Foreign Country) <i>Kennsylvania</i>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <i>MARYLAND</i>		10b. County <i>HOWARD</i>		10c. City, Town or Location <i>COLUMBIA</i>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <i>5400 VANTAGE POINT RD., APT. 108</i>				10f. Zip Code <i>21044</i>		10g. Citizen of What Country? <i>USA</i>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>WHITE</i>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>1</i> College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>RETAILER</i>			16b. Kind of Business/Industry <i>WOMENS ACCESSORIES</i>			
	17. Father's Name (First, Middle, Last) <i>SAMUEL LEVINTON</i>						18. Mother's Name (First, Middle, Maiden Summa) <i>CELIA TANFELT</i>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <i>MRS. SANDIE CASWAY (DAUGHTER)</i>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>9252 BROKEN TIMBER WAY COLUMBIA, MD 21045</i>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>MONTEFIORE</i>			Date <i>8-28-1996</i>		20c. Location - City or Town, State <i>JENKINTOWN, PHILA., PA.</i>	
	21. Signature of Funeral Service Licensee <i>Michael Kruger</i>						22. Name and Address of Facility <i>SOI Levinson &amp; Bros., Inc. 8900 Reisterstown Road Pikesville, MD 21208</i>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>a. Congestive Heart Failure</i> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>b. Due to (or as a consequence of):</i> <i>c. Due to (or as a consequence of):</i> <i>d. Due to (or as a consequence of):</i>									
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Blocked Pericarditis</i>						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>[Signature]</i>						29c. License number <i>D22856</i>		29d. Date signed (Month, Day, Year) <i>August 26, 1996</i>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>John J. Leoni, 501055 Little Patuxent Pk, Columbia, MD 21044</i>										
31. Date filed (Month, Day, Year) <i>AUG 29 1996</i>			32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

JA

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25748

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM J. ZIEGLER, SR.

2. Date of Death

Month Day Year  
Aug. 26, 1996

3. Time of Death

6:15 PM

4a. Facility Name (If not institution, give street and number)

4038 Pebble Branch Rd.

4b. City, Town, or Location of Death

Ellicott City

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

218-28-6226

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Mar. 24, 1933

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

4038 Pebble Branch Road

10f. Zip Code

21042

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☒ Yes ☐ No  
If Yes, Give Year or Dates: Korean13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4or 5+)  
5+16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Lawyer

16b. Kind of Business/Industry  
Social Security  
Administration

17. Father's Name (First, Middle, Last)

John C. Ziegler

18. Mother's Name (First, Middle, Maiden Surname)

Marie E. Franz

19a. Informant's Name/Relationship (Type, Print)

Jacqueline Ziegler (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4038 Pebble Branch Rd. Ellicott City, MD 21042

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Chesapeake Crematory

Date

Aug. 27, 1996

20c. Location - City or Town, State

Beltsville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Witzke Funeral Homes, Inc., 5555 Twin  
Knolls Rd. Columbia, Md. 2104523a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Hepatic Failure

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

6 weeks

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Gastric cancer liver mets

Due to (or as a consequence of):

18 months

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

chronic anemia, Jaundice

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
Investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury28c. Injury at  
Work?☐ Yes ☐ No  
M

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 30573

29d. Date signed (Month, Day, Year)

8-27-96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Jon K. Mumford, MD 2 Knoll North Columbia MD 21045

31. Date filed (Month, Day, Year)

AUG 29 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25749

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Anna Barker ASHFORD</b>				2. Date of Death Month Day Year <b>August 6 1996</b>		3. Time of Death <b>5:05 AM</b>																															
	4a. Facility Name (If not institution, give street and number) <b>Doctors Community Hospital</b>				4b. City, Town, or Location of Death <b>Lanham</b>		4c. County of Death <b>Prince Georges</b>																															
Funeral Director	5. Social Security Number <b>229-28-9287</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>69</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept. 5, 1926</b>																															
	9. Birthplace (State or Foreign Country) <b>Virginia</b>		10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Hyattsville</b>																															
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>6700 Belcrest Road #410</b>		10f. Zip Code <b>20782</b>		10g. Citizen of What Country? <b>U.S.A.</b>																															
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>																															
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Operator</b>		16b. Kind of Business/Industry <b>Telephone Company</b>																																	
	17. Father's Name (First, Middle, Last) <b>Thomas Bruce Anderson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Dolly Claudine Harvey</b>																																	
	19a. Informant's Name/Relationship (Type, Print) <b>Rosa Lee Saunders</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1237 Virginia Avenue #4A, Norton, VA 24273</b>																																	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Fort Lincoln Cemetery</b>		Date <b>8/8/96</b>		20c. Location - City or Town, State <b>Brentwood, Maryland</b>																															
	21. Signature of Funeral Service Licensee <b>Claudette J. Dauch</b>				22. Name and Address of Facility <b>Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781</b>																																	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																					
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td colspan="7">a. <b>End stage COPD (chronic obstructive pulmonary disease)</b> Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="3">{</td> <td colspan="7">b. <b>CHF (congestive heart failure)</b> Due to (or as a consequence of):</td> </tr> <tr> <td colspan="7">c. <b>CHF (congestive heart failure)</b> Due to (or as a consequence of):</td> </tr> <tr> <td colspan="7">d. <b>CHF (congestive heart failure)</b> Due to (or as a consequence of):</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. <b>End stage COPD (chronic obstructive pulmonary disease)</b> Due to (or as a consequence of):							{	b. <b>CHF (congestive heart failure)</b> Due to (or as a consequence of):							c. <b>CHF (congestive heart failure)</b> Due to (or as a consequence of):							d. <b>CHF (congestive heart failure)</b> Due to (or as a consequence of):						
	Immediate Cause (Final disease or condition resulting in death)	a. <b>End stage COPD (chronic obstructive pulmonary disease)</b> Due to (or as a consequence of):																																				
{		b. <b>CHF (congestive heart failure)</b> Due to (or as a consequence of):																																				
		c. <b>CHF (congestive heart failure)</b> Due to (or as a consequence of):																																				
		d. <b>CHF (congestive heart failure)</b> Due to (or as a consequence of):																																				
23b. Approximate Interval Between Onset and Death <b>2 months</b>																																						

Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
State Registrar	29b. Signature and title of certifier <b>Roiantan Farahifan M.D.</b>				29c. License number <b>D43446</b>		29d. Date signed (Month, Day, Year) <b>8/6/96</b>	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>ROINTAN FARAHIFAN - FAR 4000 Mitchumville road B216 BOWIE MD 20716</b>							
31. Date filed (Month, Day, Year) <b>AUG 08 1996</b>		32. Registrar's Signature <b>Jane Anderson-Randall</b>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25750

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Hazel Ineze Ahlers</b>				2. Date of Death Month: <b>July</b> Day: <b>19</b> Year: <b>1996</b>				3. Time of Death <b>1130A</b>				
	4a. Facility Name (If not institution, give street and number) <b>Calvert County Nursing Center</b>				4b. City, Town, or Location of Death <b>Prince Frederick Calvert</b>				4c. County of Death				
Funeral Director	5. Social Security Number <b>216 40 5884</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) <b>84</b> Yrs.		8. Date of Birth Month: <b>June</b> Day: <b>13</b> Year: <b>1912</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>				
	Usual Residence of Decedent				10a. State <b>Maryland</b>		10b. County <b>Calvert</b>		10c. City, Town or Location <b>Barstow</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number <b>Barstow Road P.O. Box 12</b>				10f. Zip Code <b>20610</b>		10g. Citizen of What Country? <b>United States</b>						
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>					
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>nurses Aid</b>		16b. Kind of Business/Industry <b>Health Care/home</b>								
	17. Father's Name (First, Middle, Last) <b>James M. Armiger</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Leila Mae Wood</b>								
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>James Mister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 12 Barstow Md. 20610</b>								
	20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Asbury Cemetery</b>				Date <b>July 23 1996</b>		20c. Location - City or Town, State <b>Barstow Maryland</b>		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Rausch Funeral Home</b> <b>4405 Broomes Is. Rd. Port Republic MD2067</b>								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>Abdominal Metastatic</b> Due to (or as a consequence of): f. <b>carcinoma</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last g. <b>unknown</b> Due to (or as a consequence of): h. <b>Primary Site</b>  Approximate Interval Between Onset and Death <b>2 yrs.</b>												
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Mellitus</b> <b>Coronary artery Disease</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)										28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier 		29c. License number <b>D 19427</b>	29d. Date signed (Month, Day, Year) <b>July 22, 1996</b>
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Anwar T. Munshi, M.D. 110 Hospital Rd. Prince Frederick Md 20678</b>													
State Registrar	31. Date filed (Month, Day, Year) <b>JUL 22 1996</b>				32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

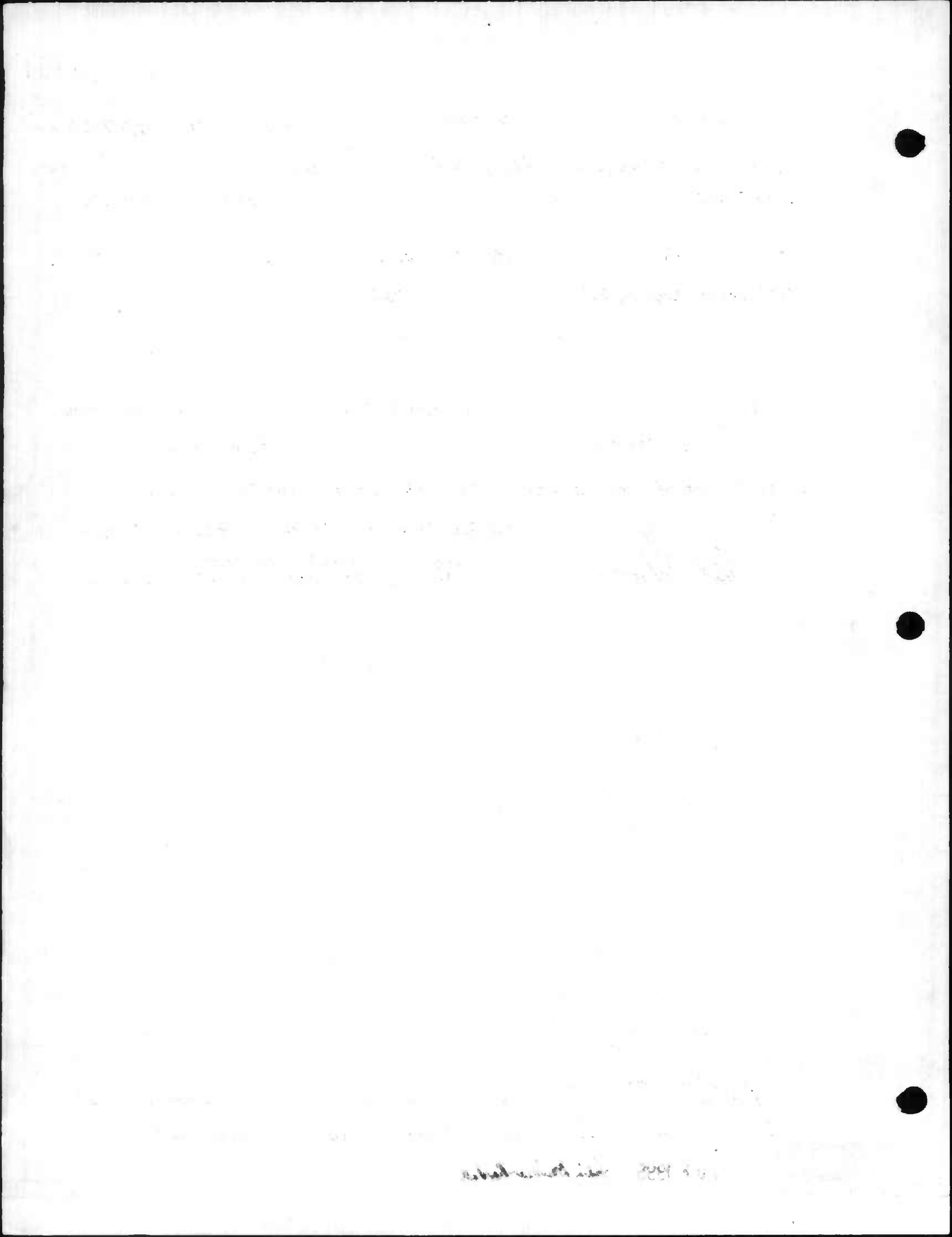
96 25751

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Easter D. Belfield		2. Date of Death Month Day Year August 7 1996		3. Time of Death 7:50 AM	
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital		4b. City, Town, or Location of Death Clinton		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 577-07-0380	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) 85	8. Date of Birth (Month, Day, Year) 4-16-11	9. Birthplace (State or Foreign Country) Virginia	
	Usual Residence of Decedent					
To Be Completed by Funeral Director	10a. State N/A	10b. County N/A	10c. City, Town or Location Washington, D.C.		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 2614 Branch Avenue, S.E.		10f. Zip Code 20020	10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Government Worker		16b. Kind of Business/Industry Federal Government	
	17. Father's Name (First, Middle, Last) Willie Ficklin		18. Mother's Name (First, Middle, Maiden Surname) Nina Haydon			
	19a. Informant's Name/Relationship (Type, Print) Mary Bresnahan/ Personal Rep.		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4305 Huntingtown Rd. Huntingtown, Md. 20639			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery 8-9-96		20c. Location - City or Town, State Suitland, Maryland	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility George P. Kalas Funeral Home 6160 Oxon Hill Road, Oxon Hill, Md. 20745			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. arteriosclerotic cardiovascular disease					Approximate Interval Between Onset and Death years
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
29b. Signature and title of certifier 		29c. License number D-18545		29d. Date signed (Month, Day, Year) August 7, 1996		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Philip Wisotsky, M.D., 700 Old Line Centre, Suite 207, Waldorf, MD 20602						
31. Date filed (Month, Day, Year) AUG 08 1996		32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



96 25752

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ELLA Mae BROWN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>July 26 1996</b>		3. TIME OF DEATH <b>6:20 AM</b>	
4. SOCIAL SECURITY NUMBER <b>579-26-3596</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>3-14-14</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Magnolia Gardens Nursing Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Lanham</b>		9c. COUNTY OF DEATH <b>Prince Georges</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince Georges</b>		10c. CITY, TOWN OR LOCATION <b>Lanham</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>6620 Ronald Road, Apt # 103</b>				10f. ZIP CODE <b>20743</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>African-American</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>John W. Brown</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mattie Butler</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Sarah B. Black</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6620 Ronald Road, Apt. #103, Capital Heights, MD 20743</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Harmony Mem. Park 8-3-96</b>		20c. LOCATION — City or Town, State <b>Landover, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>STRICKLAND Funeral Svc. 6500 Allentown Rd., Camp Springs, MD</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac Arrest</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>a. DUE TO (OR AS A CONSEQUENCE OF): <b>CVA</b></p> <p>b. DUE TO (OR AS A CONSEQUENCE OF): <b>Hypertension</b></p> <p>c. DUE TO (OR AS A CONSEQUENCE OF): <b></b></p> <p>d. DUE TO (OR AS A CONSEQUENCE OF): <b></b></p> </div> <div style="width: 30%; border-left: 1px solid black; padding-left: 10px;"> <p>Approximate Interval Between Onset and Death</p> </div> </div>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Undetermined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>D35947</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/29/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>10274 LANE PARKWAY APT #202 ANNEHOLLYWOOD, MD 20724</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 08 1996</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



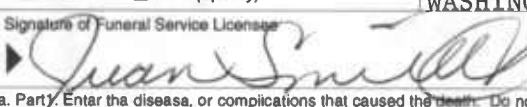
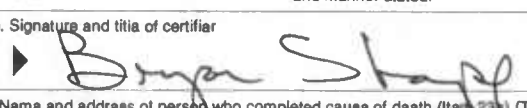
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25753

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CHARLES JOHN BURTON JR</b>					2. Date of Death Month Day Year <b>AUGUST 01, 1996</b>		3. Time of Death <b>10:39 A.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>MALCOLM GROW MEDICAL CENTER</b>					4b. City, Town, or Location of Death <b>CAMP SPRINGS</b>		4c. County of Death <b>PRINCE GEORGES</b>		
Funeral Director	5. Social Security Number <b>081-32-7822</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>73</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>SEPTEMBER 29, 1922</b>		9. Birthplace (State or Foreign Country) <b>(LOUISIANA)</b>	
	Usual Residence of Decedent									
10a. State <b>MARYLAND</b>		10b. County <b>PRINCE GEORGES</b>		10c. City, Town or Location <b>FORT WASHINGTON</b>				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number <b>7905 EAST BARRETT ROAD</b>					10f. Zip Code <b>20744</b>		10g. Citizen of What Country? <b>UNITED STATES</b>			
11. Marital Status 1 <input type="checkbox"/> Navar Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify <b>BLACK</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 YEARS</b> College (1-4 or 5+) <b>NONE</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MILITARY (RETIRED)</b>			16b. Kind of Business/Industry <b>AIR FORCE</b>			
17. Father's Name (First, Middle, Last) <b>CHARLES M. BURTON</b>					18. Mother's Name (First, Middle, Maiden Summa) <b>FRANCES COLEMAN</b>					
19a. Informant's Name/Relationship (Type, Print) <b>CHARLES BURTON III</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7905 BARRETT ROAD, FT WASHINGTON, MD., 20744</b>					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>WASHINGTON NATIONAL</b>		Data <b>8/7/96</b>		20c. Location - City or Town, State <b>SUITLAND, MD.</b>			
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>JOHN T. RHINES CO., INC. 3030 12TH ST NE, DC 20017</b>					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediata Cause (Final disease or condition resulting in death)  a. <b>SUDDEN CARDIAC DEATH</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicida 4 <input type="checkbox"/> Homicida			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 					29c. License number <b>TN MD17816</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 01, 1996</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>BRYAN C. SHARPE, MAJ, USAF, MD</b> <b>ANDREWS AIR FORCE BASE MD 20762-6600</b>										
31. Date filed (Month, Day, Year) <b>AUG 07 1996</b>					32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25754

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Dawn Elise Bowie</b>				2. Date of Death Month <b>August</b> Day <b>2</b> Year <b>1996</b>		3. Time of Death <b>5:30 P.M.</b>	
	4a. Facility Name (If not Institution, give street and number) <b>PRINCE GEORGES HOSPITAL CENTER</b>				4b. City, Town, or Location of Death <b>Cheverly</b>		4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>577-76-3995</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>41</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept. 4, 1954</b>	
	9. Birthplace (State or Foreign Country) <b>Washington, D.C.</b>		10a. State <b>District of Columbia</b>		10b. County <b>Washington</b>		10c. City, Town or Location <b>Washington</b>	
To Be Completed by Funeral Director	10e. Street and Number <b>99 55th Street, S. E.</b>		10f. Zip Code <b>20019</b>		10g. Citizen of What Country? <b>United States</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>African American</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Health Aide</b>		16b. Kind of Business/Industry <b>Private</b>			
	17. Father's Name (First, Middle, Last) <b>James Henry Aycox</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Homezelle Quivers</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Homezelle S. Aycox - Mother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>99 55th Street, S.E., Washington, D. C. 20019</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Ft. Lincoln Cemetery</b>		20c. Location - City or Town, State <b>8/6/96 Brentwood, MD</b>			
	21. Signature of Funeral Service Licensee <b>John T. Stewart III</b>				22. Name and Address of Facility <b>STEWART FUNERAL HOME, Inc. 4001 Benning Road, N. E., Washington, D. C.</b>			
	23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	Immediate Cause (Final disease or condition resulting in death) e. <b>CONGESTIVE HEART FAILURE</b> Due to (or as a consequence of): b. <b>CARDIOMYOPATHY</b> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>END STAGE RENAL DISEASE</b>							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Luminado Cruz, MD</b>		29c. License number <b>D17200</b>		29d. Date signed (Month, Day, Year) <b>8/3/96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>LUMINADO CRUZ, MD 2041 GEORGIA AVE. NW WASHINGTON DC 20060</b>								
31. Date filed (Month, Day, Year) <b>AUG 06 1996</b>		32. Registrar's Signature <b>Jabir Anderson-Rodriguez</b>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25755

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Roland Clifford Brownlee Sr.</b>				2. Date of Death Month <b>July</b> Day <b>29</b> Year <b>1996</b>		3. Time of Death <b>10:05 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Doctors Community Hospital</b>				4b. City, Town, or Location of Death <b>Lanham</b>		4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>577-26-1103</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>80</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>02-23-1916</b>		9. Birthplace (State or Foreign Country) <b>Greenville, SC</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>Prince George's</b>	10c. City, Town or Location <b>Mitchellville</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>4002 Bald Hill Ter.</b>			10f. Zip Code <b>20721</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Security Guard</b>		16b. Kind of Business/Industry <b>Federal Govt.</b>			
	17. Father's Name (First, Middle, Last) <b>Roland Brownlee</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>Julia Bates</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Larry Brownlee/Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4002 Bald Hill Ter. Mitchellville, MD 20721</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Harmony Memorial Park</b>		Data <b>08/03/1996</b>	20c. Location - City or Town, State <b>Landover, MD</b>		
	21. Signature of Funeral Service Licensee <i>Tyrone J. Young</i>				22. Name and Address of Facility <b>Tyrone J. Young Funeral Services</b> <b>5635 Eads Street, NE Washington, DC 20019</b>			
	23a. Part I. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Myocardial infarct</b> Due to (or as a consequence of): <b>b. Cardiomyopathy</b> Due to (or as a consequence of): <b>c. Arrhythmias</b> Due to (or as a consequence of): <b>d.</b>				Approximate Interval Between Onset and Death			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>hypertension</b> <b>limited physical mobility</b>							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Degenerative joint disease</b> <b>hypertension</b> <b>limited physical mobility</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28d. Describe how injury occurred		
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>D41182</b>		29d. Date signed (Month, Day, Year) <b>7/30/96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Fertan Anderson MD 9602 F MLK Jr Hwy Lanham, MD 20706</b>								
31. Date filed (Month, Day, Year) <b>AUG 06 1996</b>		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director


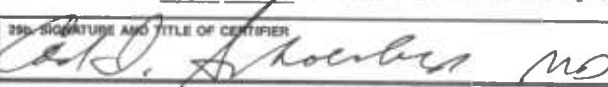



Amended #10e, P.B. &amp; C, 8/12/96

96 25756

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>OLA C. BERRY</b>				2. DATE OF DEATH MONTH <b>AUGUST</b> DAY <b>6</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>3:40 P M</b>	
4. SOCIAL SECURITY NUMBER <b>263-90-3800</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>51</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>3/27/45</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SHADY GROVE ADVENTIST HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>ROCKVILLE</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
10a. STATE <b>MD</b>				10b. COUNTY <b>MONTGOMERY</b>		10c. CITY, TOWN OR LOCATION <b>GAITHERSBURG</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>12350 FOXLAIR PLACE</b>			
10f. ZIP CODE <b>20882</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 YEARS</b> College (1-4 or 5+) <b>5+ YEARS</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>OPERATIONS RESEARCH ANALYST</b>		16b. KIND OF BUSINESS/INDUSTRY <b>RESEARCH</b>			
17. FATHER'S NAME (First, Middle, Last) <b>JOE LOUIS CARTER</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY FRANCES SCOTT</b>			
19a. INFORMANT'S NAME (Type/Print) <b>LEWIS A. BERRY</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>SAME AS 10A, B, C, D, E, &amp; F</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>PARKLAWN MEMORIAL PARK 8/10/96</b>		20c. LOCATION — City or Town, State <b>ROCKVILLE, MD.</b>		20d. DATE <b>8/10/96</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>JOHN T. RHINES CO., INC. 3030 12TH ST NE, DC 20017</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>POST OPERATIVE HEMORRHAGE and COAGULOPATHY 24 hrs.</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>SPLENECTOMY</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>SYSTEMIC SARCOIDOSIS</b> DUE TO (OR AS A CONSEQUENCE OF): d.  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>Carl I. Schoenberg MD</b>				29c. LICENSE NUMBER <b>D26540</b>		29d. DATE SIGNED (Month, Day, Year) <b>AUG 6 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Carl I. Schoenberg 16220 Frederick Rd. Gaithersburg</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 09 1996</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25757

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM EDWARD BENNETT

2. Date of Death

JULY 29, 1996

3. Time of Death

14:00 P

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

12400 SEXTON LA.

4b. City, Town, or Location of Death

BOWIE

4c. County of Death

PRINCE GEORGES

5. Social Security Number

220 26 9025

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 19, 1932

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

12400 Sexton Lane

10f. Zip Code

20715

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: Korean13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Food

17. Father's Name (First, Middle, Last)

William B. Bennett

18. Mother's Name (First, Middle, Maiden Surname)

Evelyn Simpson

19a. Informant's Name/Relationship (Type, Print)

Donna Messick Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

208 West Philadelphia Ave. Salisbury Md. 21801

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metropolitan Crematory

Date

7/31/96

20c. Location - City or Town, State

Alexandria Virginia

21. Signature of Funeral Service Licensee

Robert E. Evans, Pres.

22. Name and Address of Facility

Robert E. Evans Funeral Home, P.A.

16000 Annapolis Rd. Bowie Maryland 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?

INSPECTION

1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Dennis J. Chute M.D.

29c. License number

OCME

29d. Date signed (Month, Day, Year)

JULY 30, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 09 1996

32. Registrar's Signature

John Davidson Randall

State  
Registrar

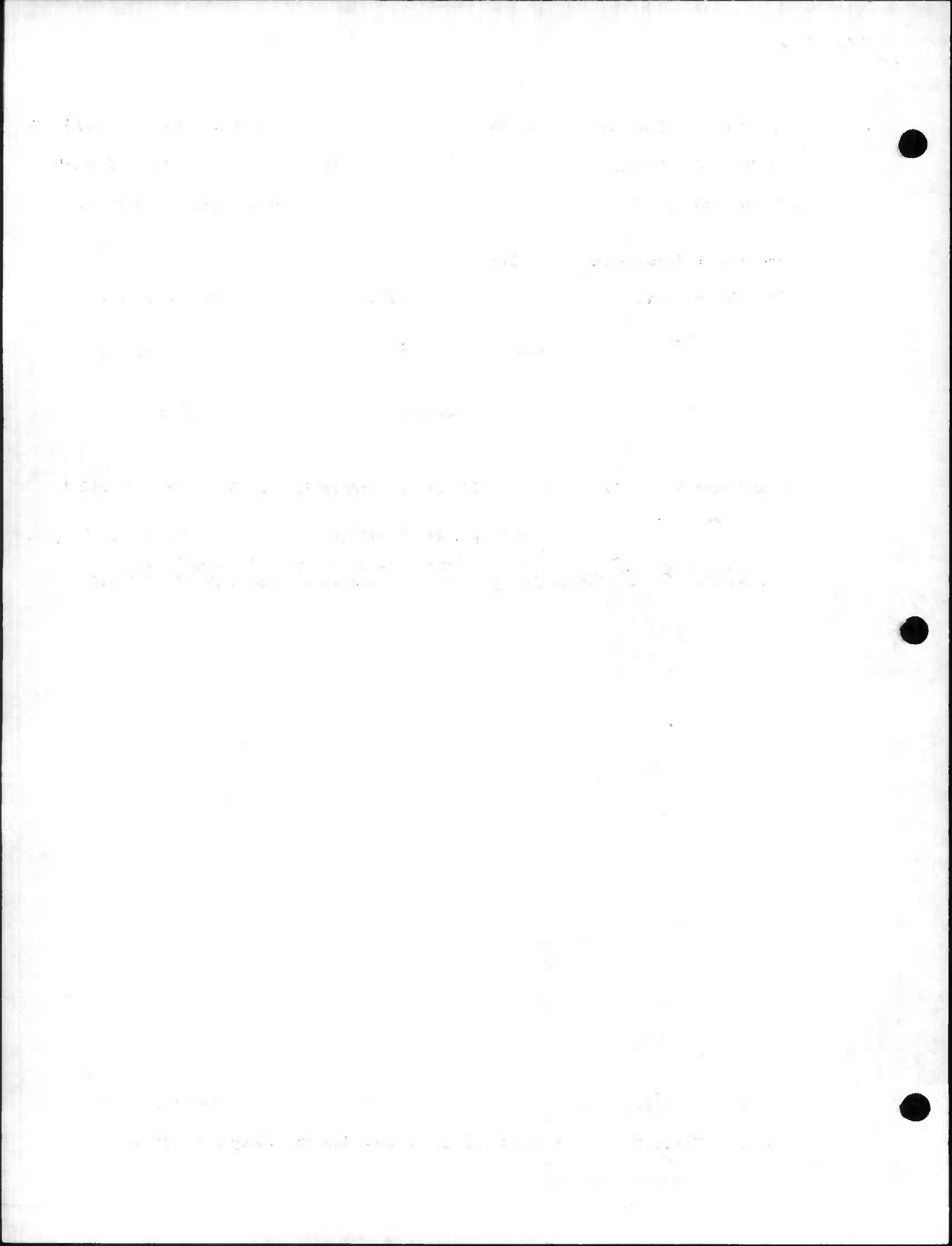
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
permit.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25758

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Katherine Pease Beardsley				2. Date of Death Month Day Year August 7, 1996				3. Time of Death 7:35 A.M.	
	4a. Facility Name (if not institution, give street and number) Manor Care- Bethesda				4b. City, Town, or Location of Death Chevy Chase				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 050-28-9221		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) December 27, 1910		9. Birthplace (State or Foreign Country) Illinois	
	Usual Residence of Decedent				10a. State Washington, D.C.		10b. County		10c. City, Town or Location Washington, D.C.	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 3900 Watson Place N.W.				10f. Zip Code 20016	
	10g. Citizen of What Country? United States				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Caucasian				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 8	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Psychologist				16b. Kind of Business/Industry U.S. Government				17. Father's Name (First, Middle, Last) Lewis Adams Pease	
	18. Mother's Name (First, Middle, Maiden Surname) Grace Muir Park				19a. Informant's Name/Relationship (Type, Print) Seymour Willis Beardsley (Husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3900 Watson Place N.W. Washington, D.C. 20016	
Physician /Medical Examiner	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Geo. Wash. University Medical Center				20c. Location - City or Town, State Washington, D.C.	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Columbia Mortuary Services, Inc. 225 Missouri Ave. NW Washington, D.C. 20011				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  ImmEDIATE Cause (Final disease or condition resulting in death)  Sequitentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <i>Pneumonia</i> Due to (or as a consequence of): b. <i>Rebilit of Rheumatoid Arthritis</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <i>1 week</i> <i>Long term</i>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicida 4 <input type="checkbox"/> Homicida 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day Year)				28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
State Registrar	29b. Signature and title of certifier 				29c. License number D0179 MD				29d. Date signed (Month, Day, Year) 8/7/96	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James Foster, MD, 5530 Wisconsin Avenue, Chevy Chase, MD 20815				31. Date filed (Month, Day, Year) AUG 09 1996				32. Registrar's Signature 	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



96 25759

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Elizabeth S. Bishop</b>				2. DATE OF DEATH MONTH <b>August</b> DAY <b>05</b> YEAR <b>1996</b>				3. TIME OF DEATH <b>0035</b> M	
4. SOCIAL SECURITY NUMBER <b>215-07-5076</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS <b>00</b> DAYS <b>00</b>		IF UNDER 24 HRS. HOURS <b>00</b> MIN. <b>00</b>	
7. DATE OF BIRTH (Month, Day, Year) <b>FEB. 15, 1911</b>				8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>SHADY GROVE ADVENTIST HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>ROCKVILLE</b>				9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
RESIDENCE OF DECEDENT									
10a. STATE <b>MD.</b>		10b. COUNTY <b>FREDERICK CO.</b>		10c. CITY, TOWN OR LOCATION <b>FREDERICK</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>910- MOTTER AVENUE</b>				10f. ZIP CODE <b>21701</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>12</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SEAMSTRESS</b>				16b. KIND OF BUSINESS/INDUSTRY <b>SEWING</b>	
17. FATHER'S NAME (First, Middle, Last) <b>ELMER G. BISHOP</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ANNIE WILHIDE</b>					
19a. INFORMANT'S NAME (Type/Print) <b>REV. DR. REICHARD</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9701- VEIRS DRIVE, ROCKVILLE, MD. 20850</b>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MT. HOPE CEMETERY</b> DATE <b>8/9</b>				20c. LOCATION — City or Town, State <b>WOODSBORO, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>W. M. Hysong</b>				22. NAME AND ADDRESS OF FACILITY <b>HYSONG CO., INC. 1300-N ST., NW, WASH., DC</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute pancreatitis</b> Approximate Interval Between Onset and Death <b>10 days</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <b>Acute pancreatitis</b> b. <b>Anteroseptal myocardial infarction</b> <b>8 days</b> c. <b>Acute cerebrovascular attack</b> <b>8 days</b> d. <b>Anemia</b> <b>Weeks</b>									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Charles W. Karesch M.D.</b>				29c. LICENSE NUMBER <b>21728</b>				29d. DATE SIGNED (Month, Day, Year) <b>August 5, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. CHARLES W. KARESCH- 1/ N. MAIN STREET, MT. AIRY, MD.</b>									
31. DATE FILED (Month, Day, Year) <b>AUG 09 1996</b>				32. REGISTRAR'S SIGNATURE <b>John Andrew Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 25760

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SHIRLEY BOWLES</b>		2. Date of Death Month Day Year <b>JULY 23 1996</b>		3. Time of Death <b>4:00 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>2108 e.marlbora avenue #204</b>		4b. City, Town, or Location of Death <b>LANDOVER</b>		4c. County of Death <b>PRINCE GEORGES</b>	
Funeral Director	5. Social Security Number <b>579-50-9596</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) <b>57</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>APRIL 18 39</b>
	9. Birthplace (State or Foreign Country) <b>WASHINGTON, D.C.</b>					
To Be Completed by Funeral Director	10a. State <b>D.C.</b>		10b. County <b>WASHINGTON</b>		10c. City, Town or Location <b>WASHINGTON</b>	
	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
	10e. Street and Number <b>3752 HAYES STREET, N.E. #4</b>		10f. Zip Code <b>20019</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH</b> Collega (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOUSEWIFE</b>		16b. Kind of Business/Industry <b>NONE</b>	
	17. Father's Name (First, Middle, Last) <b>WILLIAM CASH JR.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>HELEN L. BUTLER</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>MARY F. CASH</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1408 MERIDIAN PLACE, N.W. WASHINGTON, D.C. 20010</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>NORTHERN VIRGINIA CREM.</b>		20c. Location - City or Town, State <b>JUL 30 96 ARLINGTON, VA.</b>	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>W.H. BACON FUNERAL HOME INC. 3447 14TH STREET, N.W. WASH, D.C. 20010</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>IMMEDIATE CAUSE (Final disease or condition resulting in death):</b> <b>TERMINAL CANCER OF THE BREAST</b>  <b>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</b>  a. _____ Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						
24a. Was an autopsy performed? <b>INSPECTION</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>JULY 25, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David R. Fowler 111 Penn Street, Baltimore, Maryland 21201</b>						
31. Date filed (Month, Day, Year) <b>AUG 05 1996</b>		32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



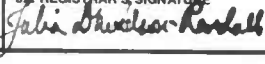
State  
Registrar



96 25761

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Rhoda N Burdnell</b>				2. DATE OF DEATH MONTH <b>7</b> DAY <b>30</b> YEAR <b>96</b>		3. TIME OF DEATH <b>7:30 a.m. M</b>	
4. SOCIAL SECURITY NUMBER <b>213-38-0458</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>70</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2/15/26</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>10028 GREEN NOCK RD</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SILVER SPRING</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY <b>MONTGOMERY</b>		10c. CITY, TOWN OR LOCATION <b>SILVER SPRING</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>10028 GREEN NOCK RD</b>				10f. ZIP CODE <b>20901</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) <b>12 YEARS</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>TEACHER</b>		15b. KIND OF BUSINESS/INDUSTRY <b>EDUCATION</b>			
17. FATHER'S NAME (First, Middle, Last) <b>DANIEL MARCELLUS NASH</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY ELLEN THOMAS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>LORRI BURDNELL FINN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1734 ROBINDALE RD, RICHMOND, VA 23235</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>FT LINCOLN CEMETERY</b>		DATE <b>8/2/96</b>		20c. LOCATION — City or Town, State <b>BRENTWOOD, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>JOHN T. RHINES CO., INC. 3030 12TH ST NE, DC 20017</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>SQUAMOUS CELL CANCER, FLOOR OF MOUTH W/METASTASES</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>RIGHT CEREBRAL STROKE</b> <b>CARDIOMYOPATHY</b> <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							Approximate Interval Between Onset and Death <b>11 MONTHS</b>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D-08695</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/30/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>GEORGE S. KENTON, MD 10620 GEORGIA AVENUE, SILVER SPRING, MD</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 05 1996</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





## Certificate of Death

Reg. No.

96 25762

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ALISON PERIE BRAND</b>		2. Date of Death Month <b>JULY</b> Day <b>30</b> Year <b>1996</b>		3. Time of Death <b>1721 P</b>
	4a. Facility Name (If not institution, give street and number) <b>20131 LOCUSTDALE DRIVE</b>		4b. City, Town, or Location of Death <b>GERMANTOWN</b>		4c. County of Death <b>MONTGOMERY</b>
Funeral Director	5. Social Security Number <b>216-78-8749</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>36</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>November 30, 1959</b>				
To Be Completed by Funeral Director	9. Birthplace (State or Foreign Country) <b>LOUISIANA</b>				
	10e. State <b>MARYLAND</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>GERMANTOWN</b>
	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number <b>20131 LOCUSTDALE DRIVE</b>		10f. Zip Code <b>20874</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>2+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SALES</b>		16b. Kind of Business/Industry <b>PRIVATE</b>
	17. Father's Name (First, Middle, Last) <b>DANIEL BRAND</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>NORMA WOODWARD</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>BRANDT SIGAFOOSE/HUSBAND</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>20131 LOCUSTDALE DR. GERMANTOWN, MD</b>		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>METROPOLITAN CREMATORY</b>		Date <b>8/2/96</b>
20c. Location - City or Town, State <b>ALEXANDRIA, VA</b>					
21. Signature of Funeral Service Licensee <i>Thawana L. Braxton</i>		22. Name and Address of Facility <b>MARSHALL'S FUNERAL HOME 4308 SUITLAND RD. SUITLAND, MD 20746</b>			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
	Immediate Cause (Final disease or condition resulting in death) <b>a. CARDIAC ARRYTHMIA</b>				
	Due to (or as a consequence of):				
	b. Due to (or as a consequence of):				
	c. Due to (or as a consequence of):				
	d. Due to (or as a consequence of):				
	Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <i>Theodore M. King</i>		29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>JULY 31, 1996</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>AUG 06 1996</b>		32. Registrar's Signature <i>Johanna R. Raskin</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25763

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HAZEL MARIE BOATMAN</b>				2. Date of Death Month <b>AUGUST 15</b> , Day <b>1996</b> Year		3. Time of Death <b>12:30 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>1704 TEMI DRIVE</b>				4b. City, Town, or Location of Death <b>WALDORF</b>		4c. County of Death <b>CHARLES</b>	
Funeral Director	5. Social Security Number <b>227-46-8328</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>57</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec. 23, 1938</b>	
	9. Birthplace (State or Foreign Country) <b>Virginia</b>		10a. State <b>Maryland</b>		10b. County <b>Charles</b>		10c. City, Town or Location <b>Waldorf</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>1704 Temi Drive</b>		10f. Zip Code <b>20601</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Waitress</b>		16b. Kind of Business/Industry <b>Food Service</b>				
17. Father's Name (First, Middle, Last) <b>Woodrow Wilson Gentry</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Lee Eaton</b>		19a. Informant's Name/Relationship (Type, Print) <b>Billy Wayne Boatman - Spouse</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1704 Temi Drive, Waldorf, MD 20601</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Maryland Veterans' Cem.</b>		20c. Location - City or Town, State <b>8-19-96 Cheltenham, MD</b>				
21. Signature of Funeral Service Licensee <b>MARK G. BROHAWN MO0053</b>		22. Name and Address of Facility <b>THE HUNT FUNERAL HOME, INC. P.O. BOX 156, WALDORF, MARYLAND 20604</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. <b>Coronary artery disease</b> Due to (or as a consequence of): b. <b>Chronic Obstructive Pulmonary Disease</b> Due to (or as a consequence of): c. <b>Hyperlipidemia</b> Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <b>13 yr.</b>				
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23c. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		
28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>John C. Patterson</b>		29c. License number <b>D19633</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 15, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JOHN C. PATTERSON, M.D., 7501 SURRATTS ROAD, #201A, CLINTON, MARYLAND 20735-3362</b>		31. Date filed (Month, Day, Year) <b>AUG 20 1996</b>		32. Registrar's Signature <b>Julia Buckner Randall</b>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25764

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>BOEKENKAMP Edward Marylin Boekenkamp</b>		2. Date of Death Month <b>5</b> Day <b>19</b> Year <b>1996</b>		3. Time of Death <b>2:10</b>
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>		4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>
Funeral Director	5. Social Security Number <b>181-03-6520</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>80</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>1/22/1916</b>	
	9. Birthplace (State or Foreign Country) <b>Pa.</b>		10. Usual Residence of Decedent		
To Be Completed by Funeral Director	10a. State <b>Del.</b>	10b. County <b>Sussex</b>	10c. City, Town or Location <b>Dagsboro</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>123 White Oak Dr., Dogwood Acres</b>		10f. Zip Code <b>19939</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>plumber</b>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>plumber</b>		16b. Kind of Business/Industry <b>plumbing</b>		
	17. Father's Name (First, Middle, Last) <b>Edward G. Boekenkamp</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Patrick</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Janet Knorr Boekenkamp</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>123 White Oak Dr., Dogwood Acres, Dagsboro De 19939</b>		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Capitol Crematory Ser.</b>		20c. Location - City or Town, State <b>8/7/96 Dover, Del.</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Watson Funeral Home, Millsboro, Delaware</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Cardiac Arrest</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Gastrointestinal Bleeding</b> <b>c. Chronic obstructive lung disease</b> Due to (or as a consequence of):  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>d. Gastrointestinal Bleeding</b> <b>e. Chronic obstructive lung disease</b>				
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. Signature and title of certifier 		29c. License number <b>17686</b>		29d. Date signed (Month, Day, Year) <b>8/5/96</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>George Gafianakis, M.D. 306 Kay Ave Salisbury, MD 21801</b>					
31. Date filed (Month, Day, Year) <b>AUG 07 1996</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25765

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ELINOR DASHIELL BOCCIA

2. Date of Death

Month Day Year  
August 5, 1996

3. Time of Death

12:55 P.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

1700 Timberlake Drive

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

5. Social Security Number

218-20-3283

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 17, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

1700 Timberlake Drive

10f. Zip Code

21801

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

J. Roland Dashiell Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Doris Disharoon

19a. Informant's Name/Relationship (Type, Print)

Patrick Boccia/spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1700 Timberlake Dr., Salisbury, MD 21801

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Parsons Cemetery

Date

8/8/96

20c. Location - City or Town, State

Salisbury, MD

21. Signature of Funeral Service Licensee

David Thompson

MOIOSI

22. Name and Address of Facility

Holloway Funeral Home

501 Snow Hill Rd., Salisbury, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)e. COPD  
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Christion Huddleston

29c. License number

D29105

29d. Date signed (Month, Day, Year)

8/7/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christion Huddleston

106 Milford St., Salisbury, MD

(410) 749-1171

31. Date filed (Month, Day, Year)

AUG 08 1996

32. Registrar's Signature

J. Davidson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





96 25766

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ROBERT JAMES BRADSHAW</b>				2. DATE OF DEATH MONTH DAY YEAR <b>August 6, 1996</b>		3. TIME OF DEATH <b>8:45 A M</b>	
4. SOCIAL SECURITY NUMBER <b>212-12-3985</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 13, 1917</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>26609 Main St., Ext. (Home)</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Crisfield</b>		9c. COUNTY OF DEATH <b>Somerset</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Somerset</b>		10c. CITY, TOWN OR LOCATION <b>Crisfield</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>26609 Main St., Ext.</b>				10f. ZIP CODE <b>21817</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>Grade 6</b> College (1-4 or 5+) <b>---</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Contractor</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Motor Freight</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Thomas Ewing Bradshaw</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Etta Sterling</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Hilda A. Bradshaw (wife)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>26609 Main St., Ext. - Crisfield, MD 21817</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Asbury Cemetery</b>		DATE <b>8/9/96</b>		20c. LOCATION — City or Town, State <b>Crisfield, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert H. Bradshaw</i> <b>Robert H. Bradshaw</b>				22. NAME AND ADDRESS OF FACILITY <b>Bradshaw &amp; Sons Funeral Home</b> <b>306 W. Main St. - Crisfield, MD 21817</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARCINOMA lung</b> Approximate interval Between Onset and Death <b>6 months</b> a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE NOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Madhav D. Barhan</i> <b>Madhav D. Barhan</b>				29c. LICENSE NUMBER <b>12764</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/6/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Madhav D. Barhan, M.D. - 4384 Crisfield Highway - Crisfield, MD 21817</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 12 1996</b>				32. REGISTRAR'S SIGNATURE <i>John A. Smith</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25767

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RUBY G. COOK

2. Date of Death

Month Day Year  
AUGUST 6, 1996

3. Time of Death

12.19 PM

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

315-24-6190

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

68

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

January 15, 1928

9. Birthplace (State or Foreign Country)

Kentucky

Usual Residence of Decedent

10a. State

Florida

10b. County

Lee

10c. City, Town or Location

Fort Meyers

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4505 Tennessee Way

10f. Zip Code

33905

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Grill Cook

16b. Kind of Business/Industry

Canteen Vending

17. Father's Name (First, Middle, Last)

Henry Nugent

18. Mother's Name (First, Middle, Maiden Surname)

Mamie Westbrooks

19a. Informant's Name/Relationship (Type, Print)

Paul M. Cook, Sr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4505 Tennessee Way, Fort Meyers, Florida 33905

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Highland Memory Gardens 8-13-96

Date

20c. Location - City or Town, State

Bullitt County, KY

21. Signature of Funeral Service Licensee

Ceri Lynn Gasch - Brady

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Septic Shock, Acidosis

Due to (or as a consequence of):

b. Bowel Infection, Gangrene

Due to (or as a consequence of):

c. Atherosclerotic Heart Disease

Due to (or as a consequence of):

d. Cardiovascular Atherosclerosis, Hypertension

Approximate Interval Between Onset and Death

10-20 hrs

1-2 days

years

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ceri Lynn Gasch - Brady

29c. License number

D 334 83

29d. Date signed (Month, Day, Year)

8/7/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PRADEEP SRIVASTAVA, M.D., 7227-B

Hannan Parkway, Greenbelt MD, 20706

State  
Registrar

31. Date filed (Month, Day, Year)

AUG 08 1996

32. Registrar's Signature

John Michael Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25768

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Barbara Elizabeth Coward - Rich				2. Date of Death Month Day Year July 31, 1996				3. Time of Death 6:30 AM				
	4a. Facility Name (If not institution, give street and number) 5427 Danby Avenue, Oxon Hill,				4b. City, Town, or Location of Death Oxon Hill				4c. County of Death Prince Georges				
Funeral Director	5. Social Security Number 238-88-7246		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 45 Yrs.		8. Date of Birth (Month, Day, Year) 5-14-51		9. Birthplace (State or Foreign Country) North Carolina				
	10a. State MD		10b. County Prince Georges		10c. City, Town or Location Oxon Hill		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
10e. Street and Number 5427 Danby Avenue		10f. Zip Code 20745		10g. Citizen of What Country? USA		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Police Officer		16b. Kind of Business/Industry U.S. Capitol Police		14. Race - American Indian, Black, White, etc. Specify: Black							
17. Father's Name (First, Middle, Last) Lloyd L. Coward Sr.				18. Mother's Name (First, Middle, Maiden Surname) Esther Arlene Tripp									
19a. Informant's Name/Relationship (Type, Print) Lloyd L. Coward Jr./ Brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9607 Old Allentown Road, Ft. Washington, MD 20744									
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park 8-05-96		20c. Location - City or Town, State Landover, MD							
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Strickland Funeral Service 9507 Silver Fox Turn, Clinton, MD 20735-3046									
23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. Small intestinal adenocarcinoma - metastatic Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death 4 years									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. NONE				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how Injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number 15897		29d. Date signed (Month, Day, Year) 8/7/96			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Joel Schectman, MD 2150 Pennsylvania Ave. NW, Washington D.C.				31. Date filed (Month, Day, Year) AUG 08 1996				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1. The first part of the report is a general  
description of the project and its objectives.  
It includes a brief history of the project and  
a statement of the problem to be solved.

2. The second part of the report is a detailed  
description of the methodology used in the study.  
It includes a description of the data collection  
methods and the statistical analysis techniques used.

3. The third part of the report is a description  
of the results of the study. It includes a  
summary of the findings and a discussion of the  
implications of the results.

4. The fourth part of the report is a conclusion  
and a list of references. The conclusion  
summarizes the main findings of the study and  
provides a final statement on the project. The  
references list the sources of information used in  
the study.

5. The fifth part of the report is a list of  
appendices. These appendices contain additional  
information that is not included in the main  
body of the report. They may include raw data,  
detailed calculations, or other supporting  
materials.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25769

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Francis E. Carr

2. Date of Death

August 4 1996

3. Time of Death

1:00 P.M.

4a. Facility Name (If not institution, give street and number)

7525 Creighton Drive

4b. City, Town, or Location of Death

College Park

4c. County of Death

Prince George's

5. Social Security Number

579-14-3287

6. Sex

M 2 F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Nov. 30, 1918

9. Birthplace (State or Foreign Country)

Washington D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

College Park

10d. Inside City Limits

Yes 2 No

10e. Street and Number

7525 Creighton Drive

10f. Zip Code

20740

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Foundryman

16b. Kind of Business/Industry

D.C. Government

17. Father's Name (First, Middle, Last)

William P. Carr

18. Mother's Name (First, Middle, Maiden Surname)

Olive Hughes

19a. Informant's Name/Relationship (Type, Print)

Patrick J. Carr son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6420 13th Street Alexandria Virginia 22307

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gate of Heaven Cemetery 8/7/96

20c. Location - City or Town, State

Silver Spring Md.

21. Signature of Funeral Service Licensee

Robert E. Evans Pres

22. Name and Address of Facility

Robert E. Evans Funeral Home, P.A.  
16000 Annapolis Rd. Bowie Md. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION SUSPECTED

Due to (or as a consequence of):

b. CAD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John A. Jackson MD

29c. License number

D36718

29d. Date signed (Month, Day, Year)

8-5-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Jackson MD, 2003 Medical Hwy, #100, Annapolis Md 21401

31. Date filed (Month, Day, Year)

AUG 09 1996

32. Registrar's Signature

Julia Anderson-Rodall

State  
Registrar

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25770

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LUCILLE CONSTANCE CURTIN</b>				2. Date of Death Month: <b>JULY</b> Day: <b>31</b> Year: <b>1996</b>		3. Time of Death <b>12:05AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>FORT WASHINGTON HOSPITAL</b>				4b. City, Town, or Location of Death <b>Ft. Washington</b>		4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>228-18-1144</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>74</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>10/11/21</b>	
	9. Birthplace (State or Foreign Country) <b>Tazewell, Va.</b>		10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Ft. Washington</b>	
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>13002 Venango Rd.</b>		10f. Zip Code <b>20744</b>		
10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): <b>12th</b> College (1-4or 5+):		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Bank Teller</b>		16b. Kind of Business/Industry <b>Banking</b>		
17. Father's Name (First, Middle, Last) <b>William G. Saunders</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Rosa L. Norman</b>				
19a. Informant's Name/Relationship (Type, Print) <b>E. Dennis Duvall</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>same as item 10</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Washington National Cem.</b>		20c. Date <b>8/3/96</b>		20d. Location - City or Town, State <b>Suitland, Md.</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>George P. Kalas Funeral Home 6160 Oxon Hill Rd., Oxon Hill, Md. 20745</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>c. SEPSIS</b> Due to (or as a consequence of): <b>b. CONGESTIVE HEART FAILURE</b> Due to (or as a consequence of): <b>c. RENAL FAILURE</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>d.</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>C.O.P.D.</b>								
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>D-45365</b>		29d. Date signed (Month, Day, Year) <b>JULY 31, 1996</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>MICHAEL SIDAROUS, M.D., 11701 LIVINGSTON RD., #101, FT. Washington</b>								
31. Date filed (Month, Day, Year) <b>AUG 05 1996</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

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State of Maryland / Department of Health and Mental Hygiene

96 25771

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SARAH ELIZABETH CROSS</b> <i>SARAH CROSS</i>				2. Date of Death Month <i>AUGUST</i> Day <i>16</i> Year <i>1996</i>		3. Time of Death <i>2 am</i>		
	4a. Facility Name (If not institution, give street and number) <i>Southern Maryland Hospital</i>				4b. City, Town, or Location of Death <i>Clinton</i>		4c. County of Death <i>Prince George's</i>		
Funeral Director	5. Social Security Number <b>214-46-6775</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>89</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>JULY 28, 1907</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
	Usual Residence of Decedent								
10a. State <b>MARYLAND</b>		10b. County <b>PRINCE GEORGE'S</b>		10c. City, Town or Location <b>UPPER MARLBORO</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>14106 RECTORY LANE</b>				10f. Zip Code <b>20773</b>		10g. Citizen of What Country? <b>UNITED STATES</b>			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>0</b>				18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>			16b. Kind of Business/Industry <b>OWN HOME</b>		
17. Father's Name (First, Middle, Last) <b>JAMES ROBERT CROSS</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ROSA GARNER</b>					
19a. Informant's Name/Relationship (Type, Print) <b>JAMES A. CROSS - NEPHEW</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. BOX 293, UPPER MARLBORO, MARYLAND 20773</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>IMMANUEL U. METHODIST CEM.</b>		Date <b>AUG. 20, 1996</b>		20c. Location - City or Town, State <b>BADEN, MD.</b>			
21. Signature of Funeral Service Licensee <i>Mark G. Brohawn</i> <b>MARK G. BROHAWN M00053</b>				22. Name and Address of Facility <b>THE HUNT FUNERAL HOME, INC.</b> <b>P.O. BOX 156, WALDORF, MARYLAND 20604</b>					
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  e. <i>Rt lower lobe pneumonia</i> Due to (or as a consequence of): b. <i>Alzheimer's dementia</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Approximate interval Between Onset and Death <i>50 days</i> <i>75 yr</i>									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>John Davidson Randall</i>							
		29c. License number <b>D-24535</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 16, 1996</b> <i>8/16/96</i>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Laxmi Bawa</i> <b>7700 OLD BRANCH Avenue</b> <i>Clinton Maryland</i> <b>20735</b>									
31. Date filed (Month, Day, Year) <b>AUG 20 1996</b>		32. Registrar's Signature <i>John Davidson Randall</i>							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28e show any injury or other traumatic event, a Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

96 25772

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JAMES MICHAEL CLEARY, SR.</b>			2. Date of Death <b>AUGUST 8 18 96</b>		3. Time of Death <b>1015am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Charles County Rehabilitation Ctr.</b>			4b. City, Town, or Location of Death <b>La Plata</b>		4c. County of Death <b>Charles</b>	
Funeral Director	5. Social Security Number <b>216-46-8981</b>		6. Sex <b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>99</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 11, 1897</b>
	9. Birthplace (State or Foreign Country) <b>Virginia</b>						
To Be Completed by Funeral Director	Usual Residence of Decedent						
	10a. State <b>Maryland</b>		10b. County <b>Charles</b>		10c. City, Town or Location <b>La Plata</b>		10d. Inside City Limits <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>
	10e. Street and Number <b>6090 Hawthorne Road</b>			10f. Zip Code <b>20646</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</b>		14. Race - American Indian, Black, White, etc. <b>Specify: White</b>
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 6</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Machinist</b>		16b. Kind of Business/Industry <b>Federal Government</b>		
	17. Father's Name (First, Middle, Last) <b>Michael Stephen Cleary</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Jennie Mary Harrison</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Eileen M. Wright</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P. O. Box 386, Marbury, MD 20658</b>			
	20a. Method of Disposition <b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Trinity Memorial Gds</b>		20c. Location - City or Town, State <b>Waldorf, Maryland</b>		
	21. Signature of Funeral Service Licensee <b>Mark G. Brohawn M00053</b>		22. Name and Address of Facility <b>Hunt Funeral Home, Inc. P. O. Box 156, Waldorf, MD 20604-0156</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. atherosclerotic cardiovascular disease</b> Due to (or as a consequence of): <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>						
23b. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</b>							
24a. Was an autopsy performed? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>							
24b. Were autopsy findings available prior to completion of cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>							
25. Was case referred to medical examiner? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>							
26. Place of Death (Check only one) Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>							
27. Manner of Death <b>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined</b>		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>							
29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>D22574</b>		29d. Date signed (Month, Day, Year) <b>AUG. 8/18/96</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. R. Timothy Pace, P. O. Box 249, Waldorf, MD 20604</b>							
31. Date filed (Month, Day, Year) <b>AUG 20 1996</b>		32. Registrar's Signature <b>[Signature]</b>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25773

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>RUTH E. COX</b>			2. Date of Death Month <b>August</b> Day <b>7</b> Year <b>1996</b>			3. Time of Death <b>0831</b>		
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>			4b. City, Town, or Location of Death <b>SALISBURY</b>			4c. County of Death <b>WICOMICO</b>		
Funeral Director	5. Social Security Number <b>219-05-3154</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>81</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>8/5/1915</b>	9. Birthplace (State or Foreign Country) <b>Md.</b>		
	Usual Residence of Decedent								
10a. State <b>Md</b>		10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Tyaskin</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>22261 Nanticoke Road</b>				10f. Zip Code <b>21865</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Seamstress</b>			16b. Kind of Business/Industry <b>Clothing</b>		
17. Father's Name (First, Middle, Last) <b>William Watson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>GRACE White</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Buddy Cox</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21790 Patriot Drive, Salisbury, Md 21801</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bivalve Cemetery</b>		Date <b>8/10</b>		20c. Location - City or Town, State <b>Bivalve, Md.</b>	
21. Signature of Funeral Service Licensee <i>[Signature]</i> <b>MOO-417</b>				22. Name and Address of Facility <b>Messick Funeral Home, P.O. Box 61 Bivalve, Maryland 21814</b>					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a. <b>CONGESTIVE HEART FAILURE</b> Due to (or as a consequence of): b. <b>CARDIO MYOPATHY</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Aspirin Intoxication, Recent onset</b> <b>Pneumonia</b> <b>Lower GI bleed, Acute</b>									23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier <i>[Signature]</i>			29c. License number <b>D39813</b>		29d. Date signed (Month, Day, Year) <b>8/17/96</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>WATKINS MD 1104 Healthway Drive, Salisbury 21801</b>									
31. Date filed (Month, Day, Year) <b>AUG 09 1996</b>			32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at 90268.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25774

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HERMAN Richard CHRISTOPHER</b>				2. Date of Death Month Day Year <b>Aug. 9 1996</b>		3. Time of Death <b>4:55 Am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Salisbury Center; Genesis ElderCare</b>				4b. City, Town, or Location of Death <b>Salisbury, Md.</b>		4c. County of Death <b>Wicomico</b>	
Funeral Director	5. Social Security Number <b>219-09-0016</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>92</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 4 1904</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland Somerset</b>		10b. County <b>Eden</b>		10c. City, Town or Location		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>14030 Backbone Road</b>				10f. Zip Code <b>21822</b>		10g. Citizen of What Country? <b>U.S.A</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>		16b. Kind of Business/Industry <b>None</b>			
	17. Father's Name (First, Middle, Last) <b>Samuel Christopher</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lillie Waters</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Malinda Stanford</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14030 Backbone Road, Eden Md. 21822</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Flower Hill</b>		Data <b>8/14</b>		20c. Location - City or Town, State <b>Eden, Md.</b>	
	21. Signature of Funeral Service Licensee <b>Gladys B. Stewart</b>				22. Name and Address of Facility <b>Stewart Funeral Home 821 West Rd. Salisbury, Md. 21801</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <u>Prostate Cancer</u></p> <p>b. <u>CNF</u></p> <p>c. <u>Atherosclerosis</u></p> <p>d. _____</p> </div> <div style="width: 35%;"> <p>Approximate Interval Between Onset and Death</p> <p><u>yes</u></p> <p><u>yes</u></p> <p><u>yes</u></p> </div> </div> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <b>[Signature]</b>				29c. License number <b>D-29349</b>		29d. Date signed (Month, Day, Year) <b>8/9/96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. WILLIAM ROBINS, 1104 HEALTHWAY DR., SALISBURY, MD. 21804</b>								
31. Date filed (Month, Day, Year) <b>AUG 12 1996</b>				32. Registrar's Signature <b>[Signature]</b>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-535-0058.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25775

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Julia Pauline Chance

2. Date of Death

Month Day Year  
June 19, 1996

3. Time of Death

1230 hrs

4a. Facility Name (If not institution, give street and number)

Union Hospital of Cecil County

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

Funeral  
Director

5. Social Security Number

218-48-6499

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

August 14, 1902

9. Birthplace (State or Foreign Country)

Delaware

Usual Residence of Decedent

10a. State

Maryland

10b. County

Kent

10c. City, Town or Location

Galena

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

144 North Main Street

10f. Zip Code

21635

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic / Own Home

17. Father's Name (First, Middle, Last)

Edward Burris

18. Mother's Name (First, Middle, Maiden Surname)

Julia Maybrey

19a. Informant's Name/Relationship (Type, Print)

John Earle Chance

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1359 Augustine Heman Highway, Galena, Maryland 21635

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Galena Cemetery, June 22, 1996

Date

20c. Location - City or Town, State

Galena, Maryland

21. Signature of Funeral Service Licensee

William L. King Jr.

22. Name and Address of Facility

Fellows, Helfenbein &amp; Newnam Funeral Home, P.A.

370 Cypress Street, Millington, Maryland 21651

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiogenic Shock

Due to (or as a consequence of):

Days

b. Congestive Cardiomyopathy

Due to (or as a consequence of):

months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Coronary Artery Disease

Due to (or as a consequence of):

Years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Viral URI

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Robert P. Denitzio

29c. License number

D30291

29d. Date signed (Month, Day, Year)

6/21/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert P. Denitzio, MD, 111 W. High Street, Elkton, MD

31. Date filed (Month, Day, Year)

JUN 28 '96

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25776

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jeanette Sparks Coleman					2. Date of Death Month Day Year June 4, 1996			3. Time of Death 1620	
	4a. Facility Name (If not institution, give street and number) Kent & Queen Anne's Co. Hospital Inc					4b. City, Town, or Location of Death Chestertown			4c. County of Death Kent	
Funeral Director	5. Social Security Number 213-24-2690		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 66 Yrs.		8. Date of Birth (Month, Day, Year) February 22, 1930		9. Birthplace (State or Foreign Country) Queen Annes Co, MD	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Queen Annes		10c. City, Town or Location Chestertown				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 205 Deep Landing Road				10f. Zip Code 21620		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collegia (1-4or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary				16b. Kind of Business/Industry Agricultural			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Clinton Sparks					18. Mother's Name (First, Middle, Maiden Summa) Edna Moore				
	19a. Informant's Name/Relationship (Type, Print) Marion Coleman/Husband					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 Deep Landing Road, Chestertown, Maryland 21620				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Crumpton Cemetery/June , 1996		20c. Location - City or Town, State Crumpton, Maryland					
	21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate interval between Onset and Death 1 week	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebrovascular Accident s/r Insulin dependant diabetes mellitus								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
State Registrar	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 							
	29c. License number D16488		29d. Date signed (Month, Day, Year) 6/6/96							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wayne D Benjamin, M.D., Chestertown, MD									
31. Date filed (Month, Day, Year) JUN 07 '96										
32. Registrar's Signature 										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28c-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

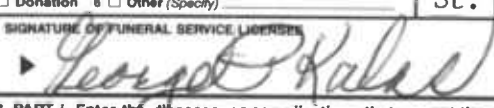
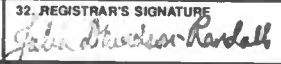
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



96 25777

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>AGNES T. DENTLINGER</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>03</b> YEAR <b>96</b>		3. TIME OF DEATH <b>10:40 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>083-10-1573</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>99</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug. 13, 1896</b>	
8. BIRTHPLACE (State or Foreign Country) <b>New York</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Malcolm Grow Medical Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Andrews Air Force Base</b>	
9c. COUNTY OF DEATH <b>Prince George's</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince George's</b>	
10c. CITY, TOWN OR LOCATION <b>District Heights</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>7102 Nimitz Dr.</b>	
10f. ZIP CODE <b>20747</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>2</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Executive Secretary</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Private Industry</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Christian Dentlinger</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Anna Marie Krumpelman</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Donald Hemmer, Jr. Great Nephew</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2310 Wintergreen Ave. District Hgts., Md. 20745</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. Plus Cemetery 8/10/96</b>			
20c. LOCATION — City or Town, State <b>Cohocton, New York</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE 			
22. NAME AND ADDRESS OF FACILITY <b>George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <b>CHRONIC CONGESTIVE MYOCARDIOPATHY</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>CHRONIC HYPOXEMIA</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>S/P PREVIOUS MYOCARDIAL INFARCTION</b> <b>BILATERAL PLEURAL EFFUSION CAUSED BY CHF &amp; KIDNEY FAILURE</b> <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>			
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)  28b. TIME OF INJURY <b>M</b> 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURED  28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>Richard A. Farson MD</b>			
29c. LICENSE NUMBER <b>MD D02237</b>				29d. DATE SIGNED (Month, Day, Year) <b>8/4/96</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>12825 Old Fort Rd. Ft. Wash., MD. 20744</b>				31. DATE FILED (Month, Day, Year) <b>AUG 05 1996</b>			
32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





96 25778

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>John A Douglas</u>				2. DATE OF DEATH MONTH <u>August</u> DAY <u>13</u> YEAR <u>96</u>		3. TIME OF DEATH <u>11:15A</u> M	
4. SOCIAL SECURITY NUMBER <u>577 10 7249</u>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>77</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>July 15, 1919</u>	
8a. FACILITY NAME (If not institution, give street and number) <u>1892 Hawk Court</u>				8b. CITY, TOWN OR LOCATION OF DEATH <u>Severn</u>		8c. COUNTY OF DEATH <u>Anne Arundel</u>	
9a. STATE <u>N. Carolina</u>				9b. COUNTY <u>Franklin</u>		9c. CITY, TOWN OR LOCATION <u>Franklinton</u>	
10a. STREET AND NUMBER <u>4131 Morton Avenue</u>				10b. ZIP CODE <u>27525</u>		10c. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>white</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>9</u> College (1-4 or 5+) <u></u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Optician-self employed</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Health Care</u>	
17. FATHER'S NAME (First, Middle, Last) <u>Ernest Archibald Douglas</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Gertrude Mae Thorn</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Mrs. Merrie L. Douglas</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>same as # 10 above</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Cedar Hill Cemetery</u>		DATE <u>8/16/96</u>		20c. LOCATION — City or Town, State <u>Suitland, MD</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>William R. Jones</u>				22. NAME AND ADDRESS OF FACILITY <u>Rausch Funeral Home, P.A. Owings, MD</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Metastatic Squamous Cell of Lung</u> DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <u>3 mos.</u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <u></u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>William R. Jones</u>				29c. LICENSE NUMBER <u>031551</u>		29d. DATE SIGNED (Month, Day, Year) <u>August 13, 1996</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Karen A. DeLuca 1600 S. Crain Highway, Green Bump, MD 21061</u>							
31. DATE FILED (Month, Day, Year) <u>AUG 15 1996</u>		32. REGISTRAR'S SIGNATURE <u>John Davidson Randall</u>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25779

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James Edward Deedon

2. Date of Death

May 30, 1996

3. Time of Death

9:05 P.M.

4a. Facility Name (If not institution, give street and number)

Meridian Nursing Center

4b. City, Town, or Location of Death

Centreville

4c. County of Death

Queen Anne's

Funeral  
Director

5. Social Security Number

217-03-3682

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 29, 1906

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Queen Anne's

10c. City, Town or Location

Centreville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

208 Little Kidwell

10f. Zip Code

21617

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

0-11

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Caretaker

16b. Kind of Business/Industry

Yards

17. Father's Name (First, Middle, Last)

Winters Deedon Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Josephine UNK.

19a. Informant's Name/Relationship (Type, Print)

Mrs. Diane Johnson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

208 Little Kidwell St. Centreville, Md. 21617

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesterfield Cemetery

Date

20c. Location - City or Town, State

Centreville, Md.

21. Signature of Funeral Service Licensee

Kenneth W. Deedon

22. Name and Address of Facility

WALLEY FUNERAL HOME

Centreville, Maryland 21617

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of):

Peripartur Vascular Disease

Approximate Interval Between Onset and Death

YRS.

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Gangrene of leg

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Gary J. Sprouse

29c. License number

D32036

29d. Date signed (Month, Day, Year)

6/6/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gary J. Sprouse M.D. 2108 Red Apple Plz. Chester, Maryland 21619

31. Date filed (Month, Day, Year)

JUN 07 '96

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25780

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOHN FRANCIS DUPIN</b>		2. Date of Death Month <b>July</b> Day <b>31</b> Year <b>1996</b>		3. Time of Death <b>0116</b>
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>		4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>
Funeral Director	5. Social Security Number <b>139-14-3736</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>76</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>November 3, 1919</b>		9. Birthplace (State or Foreign Country) <b>New York, NY</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State <b>Delaware</b>		10b. County <b>Sussex</b>
	10c. City, Town or Location <b>Rehoboth Beach</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>1003 10th Street, Bay Vista</b>		10f. Zip Code <b>19971</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Administrator</b>
	16b. Kind of Business/Industry <b>Hospital</b>		17. Father's Name (First, Middle, Last) <b>Edward August Dupin</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Henrietta Menaldino</b>
	19a. Informant's Name/Relationship (Type, Print) <b>Renate Alice Dupin</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1003 10th Street, Bay Vista</b>		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Eastern Shore Crematorium</b>		20c. Location - City or Town, State <b>Lewes, Delaware</b>
	20d. Date <b>07/31/96</b>		21. Signature of Funeral Service Licensee 		
	22. Name and Address of Facility <b>Parsell Atkins &amp; Lodge Funeral Home 1449 Kings Highway, Lewes, DE 19958</b>				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>e. Carcinogenic Shock</b> Due to (or as a consequence of): <b>b. Acute Myocardial Infarction</b> Due to (or as a consequence of): <b>c. CAD</b> Due to (or as a consequence of): <b>d.</b>				Approximate Interval Between Onset and Death <b>3r</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
	29b. Signature and title of certifier 		29c. License number <b>20441</b>		29d. Date signed (Month, Day, Year) <b>July 31, 1996</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JOSEPH RAFFETTO, M.D. 403 LINDSEY ST. SALISBURY, MD</b>					
State Registrar	31. Date filed (Month, Day, Year) <b>AUG 05 1996</b>		32. Registrar's Signature 		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25781

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ALVIN EDWARDS

2. Date of Death

Month Day Year

8 4 96

3. Time of Death

7:10 AM

4a. Facility Name (If not institution, give street and number)

HYATTSVILLE HEALTH CARE CENTER

4b. City, Town, or Location of Death

Hyattsville

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

579 74 7607

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

43 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

7 28 53

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10e. State

10b. County

10c. City, Town or Location

10d. Inside City Limits

District of Columbia

Washington

1 Yes 2 No

10e. Street and Number

2513 North Capitol Street, N. E.

10f. Zip Code

20002

10g. Citizen of What Country?

United States

11. Marital Status

1 X Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify:  
African American

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Vendor

16b. Kind of Business/Industry

Self Employed

17. Father's Name (First, Middle, Last)

Framous Frank Edwards

18. Mother's Name (First, Middle, Maiden Surname)

Patsy Ann Collins

19e. Informant's Name/Relationship (Type, Print)

Patsey Ann Gray - Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2513 North Capitol Street, N.E., Washington, D.C. 20002

20e. Method of Disposition

1 X Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Park

Date

8/10/96

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

STEWART FUNERAL HOME, Inc.

4001 Benning Road, N.E., Washington, D.C.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. AIDS

Due to (or as a consequence of):

b. Pneumonia

Due to (or as a consequence of):

c. Anemia

Due to (or as a consequence of):

d. CARDIOPULMONARY FAILURE

Approximate Interval Between Onset and Death

Years

2 weeks

2 weeks

Immediate

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

WASTING SYNDROME

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24e. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

Other:

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide  
5 Pending investigation 6 Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert D Skipworth MD

29c. License number

D28906

29d. Date signed (Month, Day, Year)

8-4-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert D Skipworth MD 585 MAIN Street, LAUREL, MD 20707

31. Date filed (Month, Day, Year)

AUG 06 1996

32. Registrar's Signature

John T. Stewart III

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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96 25782

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARGARET M. ENGEL</b>				2. DATE OF DEATH MONTH <b>AUGUST</b> DAY <b>4</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>7:40 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>220-18-2696</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>91</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	7. DATE OF BIRTH (Month, Day, Year) <b>AUG. 31, 1904</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>NATIONAL LUTHERAN HOME</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>ROCKVILLE</b>		9c. COUNTY OF DEATH <b>MONTGOMERY CO.</b>	
10a. STATE <b>MD.</b>				10b. COUNTY <b>BALTIMORE CITY</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>916- BARDSWELL ROAD</b>		10f. ZIP CODE <b>21228</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>DECORATOR</b>				16b. KIND OF BUSINESS/INDUSTRY <b>DECORATING</b>			
17. FATHER'S NAME (First, Middle, Last) <b>CHRISTIAN H. ENGEL</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ELIZABETH WEBER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>REV. DR. REICHARD</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9701- VEIRS DRIVE, ROCKVILLE, MD. 20850</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>WOODLAWN CEMETERY 8/7</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>W. M. Hyson</b>				22. NAME AND ADDRESS OF FACILITY <b>HYSOYNG CO., INC. 1300- N STREET, NW, WASH., DC</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Congestive Heart Failure</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <b>Arteriosclerotic Coronary Artery Disease</b> b. <b>Due to (or as a consequence of):</b> c. <b>Due to (or as a consequence of):</b> d. <b>Due to (or as a consequence of):</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Angina Pectoris, Arteriosclerotic Cerebral Vascular Disease with dementia, Hearing loss, Gastritis</b> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <b>0</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Christopher M. D.</b>				29c. LICENSE NUMBER <b>013368</b>		29d. DATE SIGNED (Month, Day, Year) <b>August 5, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. CHRISTOPHER SCHEMM- CHURCH STREET, DAMASCUS, MD.</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 9 1996</b>		32. REGISTRAR'S SIGNATURE <b>John H. Anderson</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25783

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Carl Thomas Estep</b>				2. Date of Death Month <b>August</b> Day <b>16</b> Year <b>1996</b>		3. Time of Death <b>10:40 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Calvert Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Prince Frederick</b>		4c. County of Death <b>Calvert</b>	
Funeral Director	5. Social Security Number <b>214-52-7493</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>47</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>March 25, 1949</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Tracys Landing</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>6225 Franklin Gibson Road</b>		10f. Zip Code <b>20779</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (14 or 5+) <b>3</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Recreational Therapist</b>		16b. Kind of Business/Industry <b>Government</b>				
17. Father's Name (First, Middle, Last) <b>William Eugene Estep, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Gladys Curtis</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Carla Estep/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>581 S. 72nd Ave. Apt. 1 Pensacola, FL 32506</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Carter's UM Church Cem.</b>		20c. Date <b>8/20/96</b>		20d. Location - City or Town, State <b>Friendship, MD</b>		
21. Signature of Funeral Service Licensee <b>Spencer S. Sewell</b>				22. Name and Address of Facility <b>Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>CARDIOPULMONARY ARREST</b> Due to (or as a consequence of): b. <b>UREMIA</b> Due to (or as a consequence of): c. <b>END STAGE RENAL DISEASE</b> Due to (or as a consequence of): d. <b>DIABETES MELLITUS</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ACQUIRED IMMUNE DEFICIENCY SYNDROME</b>								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Marcia Sherman</b>				29c. License number <b>D44618</b>		29d. Date signed (Month, Day, Year) <b>August 16 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Sherman Prince Frederick, Md. 20678</b>								
31. Date filed (Month, Day, Year) <b>AUG 19 1996</b>				32. Registrar's Signature <b>Shirley Davidson-Randall</b>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Page 100

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 25784

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

ROBERT WILLIAM

ERICKSON

2. Date of Death

Month Day Year  
AUGUST 08, 1996

3. Time of Death

7:58 AM

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

BALTIMORE

5. Social Security Number

021-24-6976

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

66

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
12/08/1929

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

SOMERSET

10c. City, Town or Location

PRINCESS ANNE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

11600 BECKFORD AVENUE

10f. Zip Code

21853

10g. Citizen of What Country?

U.S.

11. Marital Status

☐ Navar Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No  
If Yes, Give Year or Dates: KOREAN

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

BIO CHEMIST

16b. Kind of Business/Industry

PHARMACEUTICAL

17. Father's Name (First, Middle, Last)

OTTO WILLIAM ERICKSON

18. Mother's Name (First, Middle, Maiden Summa)

RUTH HOUGHTELLING

19a. Informant's Name/Relationship (Type, Print)

ANN RAE ERICKSON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11600 BECKFORD AVE., PRINCESS ANNE, MD. 21853

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SALISBURY CREMATORY

Date

8/10

20c. Location - City or Town, State

SALISBURY, MD.

21. Signature of Funeral Service Licensee

MO0295

22. Name and Address of Facility

HINMAN FUNERAL HOME  
11673 SOMERSET AVE., PRINCESS ANNE, MD. 21853

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary Aspergillosis

weeks

Due to (or as a consequence of):

b. Chronic Myelogenous Leukemia

years

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Elizabeth Claire Dees MD

29c. License number

N9673

29d. Date signed (Month, Day, Year)

August 8, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Elizabeth Claire Dees 600 N. Wolfe Street

31. Date filed (Month, Day, Year)

AUG 12 1996

32. Registrar's Signature

John Andrew Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25785

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Thomas Felix Frederick SR.</i>				2. Date of Death Month <i>August</i> Day <i>1</i> Year <i>1996</i>				3. Time of Death <i>2:40 AM</i>	
	4a. Facility Name (If not institution, give street and number) <i>Southern MD Hospital Center</i>				4b. City, Town, or Location of Death <i>Clinton</i>				4c. County of Death <i>Prince George's</i>	
Funeral Director	5. Social Security Number <i>578-40-0788</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>66</i> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <i>MAR 8, 1930</i>	9. Birthplace (State or Foreign Country) <i>Wash., D.C.</i>		
	Usual Residence of Decedent									
10a. State <i>N/A</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>Washington, D.C.</i>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <i>222 58th Street, N.E.</i>				10f. Zip Code <i>20019</i>		10g. Citizen of What Country? <i>United States</i>				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>BLACK</i>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10</i> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Maintenance Work</i>			16b. Kind of Business/Industry <i>Private</i>			
17. Father's Name (First, Middle, Last) <i>Richard Frederick</i>					18. Mother's Name (First, Middle, Maiden Surname) <i>Rosaline Nickens</i>					
19a. Informant's Name/Relationship (Type, Print) <i>Evelyn Frederick (wife)</i>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>222 58th St., N.E., Washington, D.C. 20019</i>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>GLENWOOD CEMETERY</i>		Date <i>8/8/96</i>		20c. Location - City or Town, State <i>WASHINGTON, D.C.</i>			
21. Signature of Funeral Service Licensee <i>Alex S. Pope</i> M859					22. Name and Address of Facility <i>ALEXANDER S. POPE FUNERAL HOMES 5538 Marlboro Pike, Forestville, Md. 20747</i>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>SEPSIS</i> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):										Approximate Interval Between Onset and Death <i>FEW DAYS</i>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>CARCINOMA OF THE Lung</i> <i>Gastrointestinal Bleeding</i>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <i>Aug 1 1996</i>		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Alex S. Pope</i> ATTENDING		29c. License number <i>D-44436</i>		29d. Date signed (Month, Day, Year) <i>Aug 02 96</i>				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>ASHVINKUMAR J PATEL 603 POSTOFFICE RD WILDFORD MD 20602</i>										
31. Date filed (Month, Day, Year) <i>AUG 07 1996</i>		32. Registrar's Signature <i>J. L. Anderson-Randall</i>								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3 0/3

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25786

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Evelyn H. Forest

2. Date of Death

Month Day Year  
July 30, 1996

3. Time of Death

2:25 A.M.

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital Center

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

577-14-8985

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
12/23/17

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Prince George's10c. City, Town or Location  
Forest Heights

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5506 Woodland Dr.

10f. Zip Code

20745

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

at home

17. Father's Name (First, Middle, Last)

Millard T. Haynie

18. Mother's Name (First, Middle, Maiden Surname)

Carrie E. Wister

19a. Informant's Name/Relationship (Type, Print)

Walter C. Forest

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as item 10

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ft. Lincoln Cemetery 8/2/96

Data

20c. Location - City or Town, State

Brentwood, Md.

21. Signature of Funeral Service Licensed

George P. Kalas

22. Name and Address of Facility

George P. Kalas Funeral Home  
6160 Oxon Hill Rd. Oxon Hill, Md. 20745

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

1 DAY

Due to (or as a consequence of):

b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

GASTROINTESTINAL BLEEDING

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

George P. Kalas

29c. License number

D-18545

29d. Date signed (Month, Day, Year)

July 30, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Philip Wisotsky, M.D., 11701 Livingston Rd., Suite 203, Ft. Washington, MD, 20744

31. Date filed (Month, Day, Year)

AUG 05 1996

32. Registrar's Signature

John A. Hurd

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

1937  
The first of the year  
was a very dry one  
and the crops were  
very poor.

The second of the year  
was a very wet one  
and the crops were  
very good.

The third of the year  
was a very dry one  
and the crops were  
very poor.

The fourth of the year  
was a very wet one  
and the crops were  
very good.

The fifth of the year  
was a very dry one  
and the crops were  
very poor.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25787

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Antionette I. Ford</b>				2. Date of Death Month <b>August</b> Day <b>08</b> Year <b>96</b>		3. Time of Death <b>2pm</b>		
	4a. Facility Name (If not Institution, give street and number) <b>GENESIS ELDER CARE NETWORK CENTER</b>				4b. City, Town, or Location of Death <b>LA PLATA</b>		4c. County of Death <b>CHARLES</b>		
Funeral Director	5. Social Security Number <b>215-70-1917</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>95</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>OCT. 22, 1900</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
	Usual Residence of Decedent								
10a. State <b>MARYLAND</b>		10b. County <b>CHARLES</b>		10c. City, Town or Location <b>POMFRET</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>#8060 POMFRET ROAD</b>				10f. Zip Code <b>20675</b>		10g. Citizen of What Country? <b>UNITED STATES</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6TH GRADE</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOUSEWIFE</b>			16b. Kind of Business/Industry <b>PRIVATE</b>		
17. Father's Name (First, Middle, Last) <b>JOHN JENKINS</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>JULIA BOWMAN JENKINS</b>				
19a. Informant's Name/Relationship (Type, Print) <b>ANN R. JOHNSON / DAUGHTER</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>#8060 POMFRET ROAD, POMFRET, MARYLAND 20675</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ST. MARY'S CHURCH CEM.</b>		Data <b>8/20/96</b>		20c. Location - City or Town, State <b>PISCATAWAY, MARYLAND</b>		
21. Signature of Funeral Service Licensee <b>Media C. Thornton Johnson</b>					22. Name and Address of Facility <b>THORNTON FUNERAL HOME, P.A. MEDIA C. THORNTON JOHNSON MO0583 #3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ARTERIOSCLEROTIC Cardiovascular Disease</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Congestive heart failure.</b> <b>c. Friction dependent diabetes Mellitus</b> <b>d. s/p R femoral neck fracture.</b>								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Congestive heart failure.</b> <b>Friction dependent diabetes Mellitus</b> <b>s/p R femoral neck fracture.</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>ROMALDO DE SOUZA, MD</b>		29c. License number <b>D 46241</b>		29d. Date signed (Month, Day, Year) <b>8/16/96</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>4801 Kenmore Ave Suite 102 Alexandria VA 22304</b>									
31. Date filed (Month, Day, Year)				32. Registrar's Signature <b>AUG 20 1996</b> <b>Julia Davidson-Randall</b>					

The first part of the report is devoted to a description of the  
 experimental apparatus and the method of measurement. The second part  
 contains the results of the measurements and a discussion of the  
 experimental errors. The third part is a summary of the results.

The experimental apparatus consists of a gas cylinder of known  
 volume, a pressure gauge, and a thermometer. The gas is expanded  
 from the cylinder into a larger volume, and the pressure and  
 temperature are measured before and after the expansion.

The results of the measurements are shown in the following table:  
 (Table with 4 columns: Initial Pressure, Final Pressure, Initial  
 Temperature, Final Temperature)

The experimental errors are estimated to be about 1% for the  
 pressure measurements and 0.5% for the temperature measurements.

In summary, the results of the experiment show that the gas  
 expands from the cylinder into the larger volume, and the pressure  
 and temperature decrease during the expansion.

The results of the experiment are in good agreement with the  
 theoretical predictions. The experimental errors are small, and the  
 results are reliable.

The experiment was carried out by the author, and the results  
 are presented in this report.

The author wishes to thank the following persons for their  
 assistance and advice:

[Signature]

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 25788

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DONALD S. FOSTER</b>				2. Date of Death Month Day Year <b>AUG. 1, 1996</b>		3. Time of Death <b>11:15 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>6987 Cromwell Dr.</b>				4b. City, Town, or Location of Death <b>Salisbury</b>		4c. County of Death <b>Wicomico</b>	
Funeral Director	5. Social Security Number <b>229-09-6841</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>APR. 16, 1922</b>	9. Birthplace (State or Foreign Country) <b>VIRGINIA</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD.</b>	10b. County <b>WICOMICO</b>	10c. City, Town or Location <b>SALISBURY</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>6987 CROMWELL DRIVE</b>				10f. Zip Code <b>21804</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SUPERVISOR PHOTO LAB.</b>		16b. Kind of Business/Industry <b>NASA</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>RAYMOND E. FOSTER, SR.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>RUTH NEWMAN</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>MARY KATHLEEN FOSTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6987 CROMWELL DR., SALISBURY, MD. 21804</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>SPRINGHILL MEM. GDNS.</b>		20c. Location - City or Town, State <b>8/5 HEBRON, MD.</b>			
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>Bounds Funeral Home, Salisbury, Md. 21804</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Respiratory Failure, Large Pleural Effusion</b> Due to (or as a consequence of): b. <b>metastatic Carcinoma @ Lung</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>7BP, old CVA, COPD</b>							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>HOSPICE</b>					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
			28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>218614</b>		29d. Date signed (Month, Day, Year) <b>8.1.96</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DEEPAK SAGGAR MD. 547 RIVERSIDE Dr. Salisbury Md. 21804</b>							
	31. Date filed (Month, Day, Year) <b>AUG 02 1996</b>				32. Registrar's Signature <i>[Signature]</i>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25789

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ALICE

M.

Fisher

2. Date of Death

Month July

Day 30

Year 1996

3. Time of Death

1739

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number

221-26-4087

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

55

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year 11/30/1940

9. Birthplace (State or Foreign Country)

Delaware

Usual Residence of Decedent

10e. State

Delaware

10b. County

Sussex

10c. City, Town or Location

Frankford

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

R.D. 3 Box 190

10f. Zip Code

19945

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

homemaking

17. Father's Name (First, Middle, Last)

James Calvin Condon

18. Mother's Name (First, Middle, Maiden Surname)

Hattie Marvil

19a. Informant's Name/Relationship (Type, Print)

Paul J. Fisher Sr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

R.D. 3 Box 190, Frankford, Del. 19945

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Carey's Cemetery

Date

8/3/96

20c. Location - City or Town, State

Millsboro, Del.

21. Signature of Funeral Service Licensee

Richard T. Watson

22. Name and Address of Facility

Watson Funeral Home, Millsboro, Del. 19966

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Refractory CHF, Respiratory Arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. COPD &amp; Bronchospasm

Due to (or as a consequence of):

c. ASCVD

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3-4

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joseph Raffetto, M.D.

29c. License number

20441

29d. Date signed (Month, Day, Year)

JULY 31, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOSEPH RAFFETTO, M.D.

403 QUINCY ST. SALISBURY, MD

31. Date filed (Month, Day, Year)

AUG 05 1996

32. Registrar's Signature

John A. Russell

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

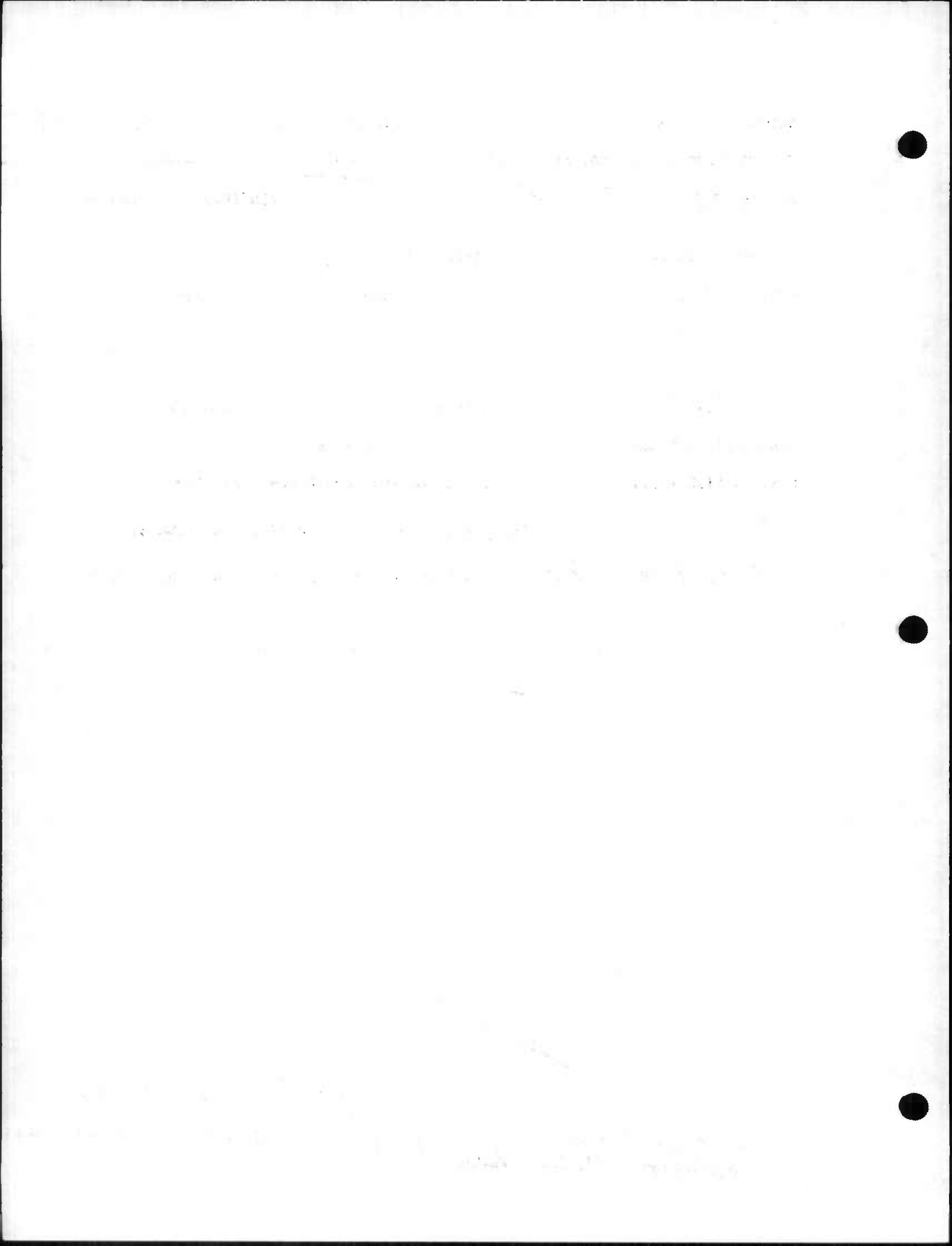
Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

State  
Registrar





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25790

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Clarence

Gibson, Jr.

2. Date of Death  
Month Day Year

August 4, 1996

3. Time of Death

11:28 P.M.

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital Center

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

262-08-9961

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

44

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

May 1, 1952

9. Birthplace (State or Foreign Country)

Florida

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Clinton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7111 Redwood Branch Court

10f. Zip Code

20735

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

I

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Accounting Clerk

16b. Kind of Business/Industry

D. C. Government

17. Father's Name (First, Middle, Last)

Clarence Gibson, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Elvira Jordan

19a. Informant's Name/Relationship (Type, Print)

Yvonne J. Owens /Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7111 Redwood Court, Clinton, Maryland 20735

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Park 8/10/96

Date

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

George P. Kalas Funeral Home

6160 Oxon Hill Rd. Oxon Hill, Md. 20745

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Acute Respiratory failure

Due to (or as a consequence of):

b. Possible pulmonary Embolism

Due to (or as a consequence of):

c. Sick cell Crisis

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

24 hours

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-33482

29d. Date signed (Month, Day, Year)

Aug 6, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sajeev Anand, M.D. 7343 Hanover Parkway, #A, Greenbelt, Md. 20770

31. Date filed (Month, Day, Year)

AUG 07 1996

Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 25791

Amended # 8. P.G.C. 8-6-96 CR

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GREGORY LIONEL

GRAY

2. Date of Death  
Month Day Year

AUGUST 02, 1996

3. Time of Death

1130AM

Funeral  
Director

4e. Facility Name (If not institution, give street and number)

HOWARD COUNTY GENERAL HOSPITAL

4b. City, Town, or Location of Death

COLUMBIA

4c. County of Death

HOWARD COUNTY

5. Social Security Number

578-66-3802

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

46 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

Aug. 2, 1949

9. Birthplace (State or Foreign Country)

Wash., DC

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

9208 Connell Court

10f. Zip Code

21046

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Computer Specialist

16b. Kind of Business/Industry

IBM

17. Father's Name (First, Middle, Last)

William McKinley Gray

18. Mother's Name (First, Middle, Maiden Surname)

Priscilla Juanita Shelton

19a. Informant's Name/Relationship (Type, Print)

Diana C. Gray

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9208 Connell Court Columbia, MD 21046

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ft. Lincoln Cemetery

Date

8-8

20c. Location - City or Town, State

Brentwood, MD

21. Signature of Funeral Service Licensee

*D. P. Marshall*

22. Name and Address of Facility

Marshall's Funeral Home, Inc.

4217 9th St. N.W., Wash DC 20011

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

*Pulmonary embolus*

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Bilateral rib fractures, organizing abdominal hematoma**morbid obesity,*

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24e. Was an autopsy performed?

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☒ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☐ Natural☒ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)

7-27-96

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

*struck another vehicle on driver's side of auto.*

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

*Roadway*

28f. Location (Street and Number or Rural Route Number, City or Town, State)

*Rt. 1 and 175-Cr.*29a. Certifier  
(Check only one)☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Donald G. Wright MD*

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

AUGUST 03, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DONALD G. WRIGHT MD

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 06 1996

32. Registrar's Signature

*John Andrew Carroll*State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e show any injury or other traumatic event, the Medical Examiner must be notified at once.

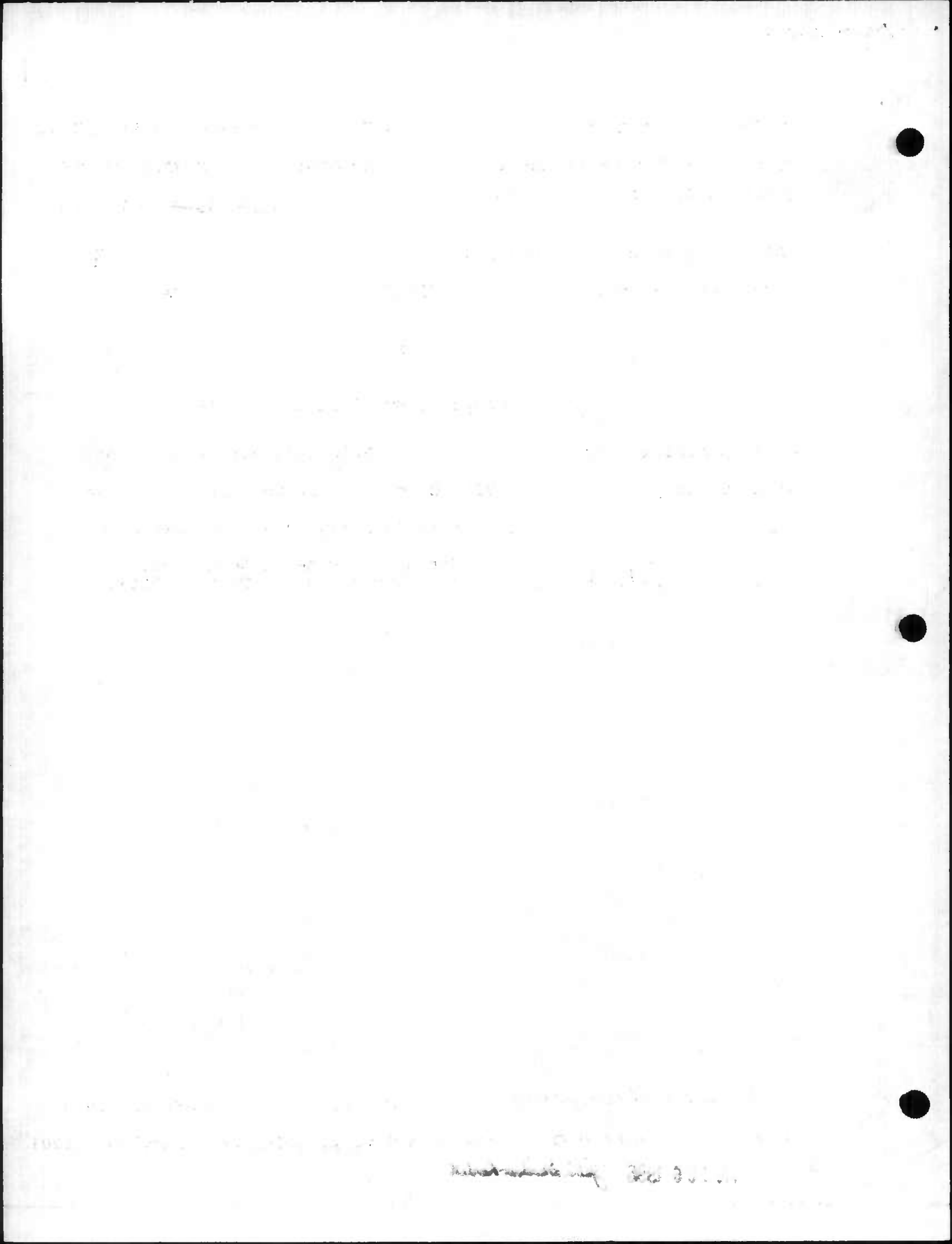
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25792

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIE ELLIS GILCHRIST

2. Date of Death

AUGUST

Day

1,

Year

1996

3. Time of Death

7:00AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

6531 LANDOVER RD

4b. City, Town, or Location of Death

LANDOVER, MD

4c. County of Death

PRINCE GEORGES

5. Social Security Number

577-64-2945

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

48

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

NOV. 19, 1947

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

WASHINGTON, D.C.

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGES

10c. City, Town or Location

LANDOVER

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

6531 LANDOVER RD

10f. Zip Code

20785

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TREE SURGEON

16b. Kind of Business/Industry

LANDSCAPING

17. Father's Name (First, Middle, Last)

WILLIE FELTON GILCHRIST

18. Mother's Name (First, Middle, Maiden Surname)

BEATRICE PRICE

19a. Informant's Name/Relationship (Type, Print)

ELIZABETH A. GILCHRIST-WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6531 LANDOVER RD LANDOVER, MD 20785

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

FT. LINCOLN CEMETERY

Date

8/7/96

20c. Location - City or Town, State

BLADENSBURG, MD

21. Signature of Funeral Service Licensee

Alex S Pope Jr.

22. Name and Address of Facility

ALEXANDER S POPE FUNERAL HOMES

5538 MARLBORO PIKE FORESTVILLE, MD 20747

23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

e. LARYNX CANCER

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

18 MONTHS

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David Perry

29c. License number

DC18961

29d. Date signed (Month, Day, Year)

AUGUST 2, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DR. DAVID PERRY 110 IRVING STREET N.W. WASHINGTON, D.C. 20010

31. Date filed (Month, Day, Year)

AUG 09 1996

32. Registrar's Signature

John A. Anderson-Karley

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. The first part of the report

is devoted to a general

description of the

method of

the investigation

and the results

obtained from the

experiments

are

discussed in

the

conclusion

of the

report

is given in

the following table

which shows the

results of the

investigation

TABLE I

Results

*[Handwritten signature]*

The results of the investigation are given in the following table

TABLE I  
Results of the investigation

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25793

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Alice Gilbert</b>				2. Date of Death Month Day Year <b>August 10 1996</b>		3. Time of Death <b>6:15PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Meridian Health Care Center, Spa Creek</b>				4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>228-30-0525</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>91</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Feb 9 1905</b>	
	9. Birthplace (State or Foreign Country) <b>Idaho</b>		10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Annapolis</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>22 Mayo Avenue</b>		10f. Zip Code <b>21403</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>5</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Teacher</b>		16b. Kind of Business/Industry <b>Education</b>		16c. Kind of Business/Industry <b>Anne Arundel County</b>		
17. Father's Name (First, Middle, Last) <b>William E. Gilbert</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mattie Crumpacker</b>				
19a. Informant's Name/Relationship (Type, Print) <b>William Gilbert-Nephew</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1614 Californa Street Huston, Texas 77006</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Ft. Lincoln Crematory 8/16/96</b>		20c. Location - City or Town, State <b>Brentwood, Maryland</b>		21. Signature of Funeral Service Licensee <i>Donald L. Taylor</i>		
22. Name and Address of Facility <b>John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Sudden, instantaneous death</b> Due to (or as a consequence of): <b>b. Likely cardiac arrhythmia</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death <b>2 minutes</b> <b>minutes</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Other: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		
29b. Signature and title of certifier <i>Peter F. Verkouw</i>		29c. License number <b>D11653</b>		29d. Date signed (Month, Day, Year) <b>August 13, 1996</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Peter F. Verkouw, M.D. 2003 Medical Parkway #100 Annapolis, MD 21401</b>		
31. Date filed (Month, Day, Year) <b>AUG 16 1996</b>		32. Registrar's Signature <i>John Davidson-Randall</i>		33. Registrar's Name <b>John Davidson-Randall</b>		34. Registrar's Title <b>Registrar</b>		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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## Certificate of Death

Reg. No.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

1. Decedent's Name (First, Middle, Last)  
ETHEL GROSS GALLOWAY

2. Date of Death  
Month Day Year  
AUG. 12 1996

3. Time of Death  
5:20 pm

4a. Facility Name (If not institution, give street and number)  
PLEASANT LIVING CONVALESCENT CENTER

4b. City, Town, or Location of Death  
EDGEWATER

4c. County of Death  
ANNE ARUNDEL

5. Social Security Number  
213-12-2106

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)  
86 Yrs.

8. Date of Birth (Month, Day, Year)  
JULY 8 1910

9. Birthplace (State or Foreign Country)  
MARYLAND

Usual Residence of Decedent

10a. State  
MARYLAND

10b. County  
ANNE ARUNDEL

10c. City, Town or Location  
ANNAPOLIS

10d. Inside City Limits  
1 ☒ Yes 2 ☐ No

10e. Street and Number  
1295 ASHTON COURT

10f. Zip Code  
21403

10g. Citizen of What Country?  
US

11. Marital Status  
1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.  
Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)  
Elementary/Secondary (0-12) 6th  
College (1-4or 5+) 0

16. Kind of Business/Industry  
SOME ONE ELSE HOME

17. Father's Name (First, Middle, Last)  
JOHN W. HARRIED

18. Mother's Name (First, Middle, Maiden Surname)  
MARTHA HOBBS

19a. Informant's Name/Relationship (Type, Print)  
DEBORAH SMITH (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
1295 ASHTON COURT ANNAPOLIS, MD. 21403

20a. Method of Disposition  
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)  
ANNAPOOLIS MEM. GARDENS

20c. Date  
8/16/96

20d. Location - City or Town, State  
ANNAPOLIS, MD.

21. Signature of Funeral Service Licensee  
Larry H. Reese

22. Name and Address of Facility  
WM. REESE & SONS MORTUARY, P.A.  
821 WEST ST. ANNAPOLIS, MD. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
e. Died Suddenly - minutes  
Due to (or as a consequence of):  
b. generalized arterio-sclerotic disease years  
Due to (or as a consequence of):  
c. chronic atrial fibrillation years  
Due to (or as a consequence of):  
d.

23b. Did tobacco use contribute to the cause of death?  
1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)  
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA  
Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death  
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury  
M

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)  
1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier  
Peter F. Verkouw MD

29c. License number  
D11653

29d. Date signed (Month, Day, Year)  
Aug. 14, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  
Peter F. VERKOUW, MD 2003 MED. PKWY, Annapolis, MD, 21401

31. Date filed (Month, Day, Year)  
AUG 15 1996

32. Registrar's Signature  
Julia Davidson-Randall



Amended #19A P.G. 8C, 8/8/96

96 25795

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Hazel Hogan</u>				2. DATE OF DEATH MONTH <u>August</u> DAY <u>4</u> YEAR <u>'96</u>		3. TIME OF DEATH <u>1:05 AM</u>	
4. SOCIAL SECURITY NUMBER <u>169-18-2713</u>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>82</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>3/9/1914</u>	
8. BIRTHPLACE (State or Foreign Country) <u>N. Carolina</u>				9a. FACILITY NAME (If not institution, give street and number) <u>Potomac Valley Nursing Home</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Rockville</u>	
9c. COUNTY OF DEATH <u>Montgomery</u>				10a. STATE <u>Maryland</u>		10b. COUNTY <u>Montgomery</u>	
10c. CITY, TOWN OR LOCATION <u>Rockville</u>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <u>1235 Potomac Valley Rd.</u>	
10f. ZIP CODE <u>20850</u>				10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>WHITE</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>UNKNOWN</u> College (1-4 or 5+) <u>Curator</u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Curator</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Pa. Historical Commission</u>	
17. FATHER'S NAME (First, Middle, Last) <u>Geogory Miles</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Mary France Boone</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Rosemary Popdan</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3613 Falling Green Rd, Olney MD. 20832</u>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Georgetown Med. Sch. 8/4/96 Washington, DC.</u>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Henry G. Gustafson</u>				22. NAME AND ADDRESS OF FACILITY <u>Austin Royster Funeral Home</u> <u>3605 14th St. N.W., Wash, DC. 20010</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>MYOCARDIAL INFARCTION</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>CORONARY ARTERY DISEASE</u> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>RENAL FAILURE</u>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Walter Goozh MD</u>				29c. LICENSE NUMBER <u>D01120</u>		29d. DATE SIGNED (Month, Day, Year) <u>August 7, 1996</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Form 27) (Type, Print) <u>Walter Goozh MD, 2309 ShoreField Rd. Wheaton, MD. 20902</u>							
31. DATE FILED (Month, Day, Year) <u>AUG 08 1996</u>				32. REGISTRAR'S SIGNATURE <u>John Davidson Carroll</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25796

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ignatius Emmanuel Hawkins

2. Date of Death

August

Day 4 Year 1996

3. Time of Death

9:33 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Doctors Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince Georges

5. Social Security Number

215-68-8438

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

38

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

09-20-57

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

8905 Maple Avenue

10f. Zip Code

20720

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

Collega (1-4 or 5+)

12th

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Printer

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname)

Pauline Yvonne Hawkins

19a. Informant's Name/Relationship (Type, Print)

Shirley Moulden/Aunt

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5646 Whitfield Chapel Rd #102, Lanham, MD 20706

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Resurrection Cemetery

Date

8/9/96

20c. Location - City or Town, State

Clinton, Maryland

21. Signatures of Funeral Service Licensee

22. Name and Address of Facility

J. B. Jenkins Funeral Home

7474 Landover Road, Landover, MD 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Cardio-Respiratory Arrest

15 min.

Due to (or as a consequence of):

b. Bilateral Pneumonia

1 week

Due to (or as a consequence of):

c. AIDS

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Renal Insufficiency

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy

performed?

1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D20727

29d. Date signed (Month, Day, Year)

August 5, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Renuka Gupta, MD 7215-D Hanover Parkway, Greenbelt, MD 20770

31. Date filed (Month, Day, Year)

AUG 07 1996

Registrar's Signature

John Andrew Handal

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MICHAEL HINTON

2. Date of Death

Month Day Year  
AUG. 6, 1996

3. Time of Death

1800 PM

4a. Facility Name (If not institution, give street and number)

PRINCE GEORGES HOSPITAL CENTER

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

PRINCE GEORGES

Funeral  
Director

5. Social Security Number

578-78-6574

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

38

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 30, 1957

9. Birthplace (State or Foreign Country)

Rocky Mt., N.C.

Usual Residence of Decedent

10a. State

District of Columbia

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2925 Massachusetts Avenue, S. E. #3

10f. Zip Code

20019

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
Black15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Warehouse Selector

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Edward Marshall

18. Mother's Name (First, Middle, Maiden Surname)

Blanche Hinton

19a. Informant's Name/Relationship (Type, Print)

Robbie L. Hinton - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2925 Massachusetts Ave., S.E., #3, Wash., D.C. 20019

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Harmony Memorial Park

Date

8/13/96

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

STEWART FUNERAL HOME, Inc.

4001 Benning Road, N.E., Washington, D.C.

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. CARDIAC HYPOTROPHY

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

{

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MORBID OBESITY

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Theodore M. King

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

AUG. 7, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THEODORE M. KING

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 09 1996

32. Registrar's Signature

John Andrew Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

2000 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25798

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William Francis Harrison, Jr.

2. Date of Death

August 2, 1996

3. Time of Death

6:10 A. M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Fort Washington Hospital

4b. City, Town, or Location of Death

Fort Washington

4c. County of Death

Prince George's

5. Social Security Number

578-38-7946

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

65

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

2-24-31

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Oxon Hill

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6812 Leyte Drive

10f. Zip Code

20745

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Mechanical Contractor

16b. Kind of Business/Industry

Self Employed

17. Father's Name (First, Middle, Last)

William F. Harrison, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Ethel Motter

19a. Informant's Name/Relationship (Type, Print)

Alma A. Harrison / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6812 Leyte Dr. Oxon Hill, Md. 20745

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify) Entombment

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resurrection Cemetery 8-5-96

Date

20c. Location - City or Town, State

Clinton, Maryland

21. Signature of Funeral Service Licensee

George P. Kalas

22. Name and Address of Facility

George P. Kalas Funeral Home  
6160 Oxon Hill Rd., Oxon Hill, Maryland, 20745

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Sudden Cardiac Death

Approximate Interval Between Onset and Death

4 minutes

Due to (or as a consequence of):

b. Ischemic Cardiomyopathy

1 year

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Allen A. Nimetz, M.D.

29c. License number

D-07147

29d. Date signed (Month, Day, Year)

August 2, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Allen A. Nimetz, M.D. 5401 Western Ave., N. W. Washington, D. C. 20015

31. Date filed (Month, Day, Year)

AUG 05 1996

32. Registrar's Signature

John D. H. Hall

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

20



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25799

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Darrell E. Hutcheson</b>				2. Date of Death Month <b>August</b> Day <b>18</b> Year <b>1996</b>		3. Time of Death <b>2:35PM</b>	
	4e. Facility Name (If not institution, give street and number) <b>6312 Walter Avenue</b>				4b. City, Town, or Location of Death <b>Camp Springs</b>		4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>215-08-1183</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>31</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct. 14, 1964</b>	
	9. Birthplace (State or Foreign Country) <b>Texas</b>		10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Camp Springs</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10a. Street and Number <b>6312 Walton Avenue</b>				10f. Zip Code <b>20746</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b>		15b. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Retail/Sales</b>		16b. Kind of Business/Industry <b>Parts Store</b>			
	17. Father's Name (First, Middle, Last) <b>Earle Wayne Hutcheson</b>		18. Mother's Name (First, Middle, Maiden Summa) <b>Carolyn Ann Smith</b>		19a. Informant's Name/Relationship (Type, Print) <b>Earle W. Hutcheson (Father)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6312 Walton Avenue Camp Springs, Maryland 20746</b>	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Resurrection Cemetery Aug. 21, 1996 Clinton, Maryland</b>		20c. Location - City or Town, State			
	21. Signature of Funeral Service Licensee <i>Jerianne Bates Cox</i>		22. Name and Address of Facility <b>Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, Md 20735</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. <b>Immunodeficiency, end stage dis.</b>		Approximate interval Between Onset and Death	
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	
	28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Vanessa Allen, M.D.</i>		29c. License number <b>044864</b>		
29d. Date signed (Month, Day, Year) <b>8-19-96</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Accokeek Family Medical Center Vanessa Allen M.D. 15901 Indian Head Highway Accokeek MD 20607</b>		31. Date filed (Month, Day, Year) <b>AUG 20 1996</b>		32. Registrar's Signature <i>Julia Davidson Randall</i>		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1942-1943  
1944-1945  
1946-1947

1948-1949  
1950-1951

1952-1953

1954-1955  
1956-1957

1958-1959  
1960-1961

1962-1963  
1964-1965

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25800

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HARVEY EARL HICKSON</b>				2. Date of Death Month Day Year <b>August 12, 1996</b>		3. Time of Death <b>10:15 AM</b>	
	4a. Facility Name (If not Institution, give street and number) <b>Salisbury Center/Genesis Eldercare</b>				4b. City, Town, or Location of Death <b>Salisbury, MD</b>		4c. County of Death <b>Wicomico</b>	
Funeral Director	5. Social Security Number <b>215-01-3595</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>83</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>OCT. 23, 1912</b>	
	9. Birthplace (State or Foreign Country) <b>MD.</b>		10a. State <b>MD.</b>		10b. County <b>WICOMICO</b>		10c. City, Town or Location <b>SALISBURY</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>NORTH PARK GARDENS</b>		10f. Zip Code <b>21801</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> Collage (1-4 or 5+) <b>MANAGER</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MANAGER</b>		16b. Kind of Business/Industry <b>INSURANCE</b>			
	17. Father's Name (First, Middle, Last) <b>CHARLES B. HICKSON, SR.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>LAURA AGNES CALLOWAY</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>H. MICHAEL HICKSON</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1117 COTTONPATCH ISLAND, SALISBURY, MD. 21801</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>PARSONS CEMETERY</b>		20c. Location - City or Town, State <b>8/15 SALISBURY, MD.</b>			
	21. Signature of Funeral Service Licensee <i>Gerald C. Bruner</i>		22. Name and Address of Facility <b>BOUNDS FUNERAL HOME, 705 E. MAIN ST., SALISBURY, MD.</b>		21804			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Fatal Pulmonary embolism</b> Due to (or as a consequence of): <b>b. Lung Cancer</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Myocardial Infarction</b>		Approximate Interval Between Onset and Death <b>minutes</b>					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Coronary Artery Disease</b> <b>Myocardial Infarction</b> <b>Chronic Kidney Disease</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>8/12/96</b>		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>D39813</b>		29d. Date signed (Month, Day, Year) <b>8/14/96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Michael Atkins MD 1104 Kentway Salisbury MD 21804</b>		31. Date filed (Month, Day, Year) <b>AUG 15 1996</b>		32. Registrar's Signature <i>[Signature]</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25801

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Clarence Franklin Hicks				2. Date of Death Month Day Year 6 4 1996		3. Time of Death 4:00 p.m.		
	4a. Facility Name (If not institution, give street and number) 6368 Rock Hall Road				4b. City, Town, or Location of Death Rock Hall		4c. County of Death Kent		
Funeral Director	5. <del>220-16-9813</del> <del>220-16-9813</del>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) 10-12-1923		
							9. Birthplace (State or Foreign Country) MD		
Usual Residence of Decedent									
10a. State MD		10b. County Kent		10c. City, Town or Location Rock Hall			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 6368 Rock Hall Road				10f. Zip Code 21661		10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1943 1946		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waterman			16b. Kind of Business/Industry Seafood		
17. Father's Name (First, Middle, Last) Oscar Clarence Hicks				18. Mother's Name (First, Middle, Maiden Surname) Ethel Rochester Hicks					
19a. Informant's Name/Relationship (Type, Print) Gertrude Hicks				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6368 Rock Hall Rd., Rock Hall, MD 21661					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Sharptown Cemetery		Data 6/10/96		20c. Location - City or Town, State Rock Hall, MD			
21. Signature of Funeral Service Licensee James A. Perkins				22. Name and Address of Facility James A. Perkins Funeral Service P. O. Box 143, Rock Hall, MD 21661					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. metastatic rectal cancer Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier m Bienenfeld				29c. License number 033514		29d. Date signed (Month, Day, Year) 6-6-96			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Bienenfeld MD 100 Brown Street Chestertown MD 21620									
31. Date filed (Month, Day, Year) JUN 07 '96				32. Registrar's Signature John Davidson-Hendall					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25802

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DANIEL G. HORNER, SR</b>				2. Date of Death Month Day Year <b>August 4, 1996</b>		3. Time of Death <b>9:20 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>At Home- 3741 Texas Rd., Bivalve, Md</b>				4b. City, Town, or Location of Death <b>Bivalve</b>		4c. County of Death <b>Wicomico</b>		
Funeral Director	5. Social Security Number <b>213-16-7823</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>Mar. 28, 1914</b>	9. Birthplace (State or Foreign Country) <b>Md.</b>				
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>Md.</b>	10b. County <b>Wicomico</b>	10c. City, Town or Location <b>Bivalve</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number <b>3741 Texas Rd</b>			10f. Zip Code <b>21814</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Truck Driver</b>			16b. Kind of Business/Industry			
	17. Father's Name (First, Middle, Last) <b>Charles Horner</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Mary E. Brown</b>					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Robert Horner</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3741 Texas Rd, Bivalve, Md. 21814</b>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Salisbury Crematory</b>		20c. Date <b>8/9</b>		20d. Location - City or Town, State <b>Salisbury, Md.</b>		
	21. Signature of Funeral Service Licensee <i>[Signature]</i> MOO-417			22. Name and Address of Facility <b>Messick Funeral Home, P.O. Box 61 Bivalve, Md. 21814</b>					
	23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death	
	Immediate Cause (Final disease or condition resulting in death) e. <b>Respiratory Failure</b> Due to (or as a consequence of): b. <b>Chronic Obstructive Lung Disease</b> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>D20683</b>		29d. Date signed (Month, Day, Year) <b>8/5/96</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>PO Box 121 NANTICOKE MD 21840 Stephen A. Laffey MD</b>									
31. Date filed (Month, Day, Year) <b>AUG 06 1996</b>		32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. The first part of the report deals with the general situation of the country and the progress of the work during the year. It also mentions the results of the various expeditions and the collections made.

2. The second part of the report describes the various expeditions and the collections made. It mentions the names of the participants and the results of the work. It also mentions the various specimens collected and the progress of the work.

3. The third part of the report deals with the general situation of the country and the progress of the work during the year. It also mentions the results of the various expeditions and the collections made.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25803

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ann B Heath</b>				2. Date of Death Month Day Year <b>August 02 1996</b>		3. Time of Death <b>12:18 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Wicomico Nursing Home</b>				4b. City, Town, or Location of Death <b>Salisbury</b>		4c. County of Death <b>Wicomico</b>	
Funeral Director	5. Social Security Number <b>218-16-5254</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>84</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 24, 1912</b>	
	9. Birthplace (State or Foreign Country) <b>Md.</b>		10a. State <b>Md</b>		10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Jesterville -Mailing Address Bivalve</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>Box 63</b>		10f. Zip Code <b>21814</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Book Keeper</b>		16b. Kind of Business/Industry <b>Seafood Industry</b>			
	17. Father's Name (First, Middle, Last) <b>Ephraim Bounds</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lucy Smith</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Barbara Ann White</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 71, Tyaskin, Md. 21865</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Oak Grove Cemetery</b>		20c. Date <b>8/5/96</b>		20d. Location - City or Town, State <b>Jesterville, Md.</b>	
	21. Signature of Funeral Service Licensee <i>[Signature]</i> <b>MOO-417</b>		22. Name and Address of Facility <b>Messick Funeral Home, P.O. Box 61 Bivalve, Maryland 21814</b>					
	23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>Ca of Breast &amp; diffuse Metastasis</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):							
	Approximate Interval Between Onset and Death							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and Title of certifier <i>[Signature]</i>		29c. License number <b>D02026</b>		29d. Date signed (Month, Day, Year) <b>8-3-96</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>F.G. Arthes, MD 1622 A Ocean Pines, Berlin, Md. 21811</b>								
31. Date filed (Month, Day, Year) <b>AUG 06 1996</b>		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

10

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25804

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Adam Jackson, Jr.

2. Date of Death

Month  
8Day  
4Year  
96

3. Time of Death

7:55 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

6511 Landover Road #204

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

5. Social Security Number

578-66-2516

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

47 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
5-5-49

9. Birthplace (State or Foreign Country)

Wash. D.C.

Usual Residence of Decedent

10a. State

Md

10b. County

Prince Georges

10c. City, Town or Location

Cheverly

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

6511 Landover Rd. Apt 204

10f. Zip Code

20785

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 yrs.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Adam Jackson Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Davis

19a. Informant's Name/Relationship (Type, Print)

Tawanna Jackson/ wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4563 Akron St. Temple Hills, Md. 20748

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Pk 8/8/96 Landover, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

J. B. Jenkins Funeral Home

7474 Landover Rd, Landover, MD 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. END STAGE AIDS

Due to (or as a consequence of):

b. MYCOBACTERIUM AVIUM INTRACELLULARE

Due to (or as a consequence of):

c. ORAL CANDIDIASIS

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D45786

29d. Date signed (Month, Day, Year)

8/5/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Clayton Straughn, MD 6525 Belcrest Rd. Hyattsville, Maryland 20782

31. Date filed (Month, Day, Year)

AUG 06 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25805

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edward R. Johnson

2. Date of Death

Month

Day

Year

8

8

1996

3. Time of Death

6:13 AM

4a. Facility Name (If not institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

577-42-3113

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

64

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

JAN 9, 1932

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

New Carrollton

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

8503 Sprague Place

10f. Zip Code

20784

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1952  
1954

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ENGINEER DRAFTSMAN

16b. Kind of Business/Industry

PRIVATE

17. Father's Name (First, Middle, Last)

CHRISTOPHER JOHNSON

18. Mother's Name (First, Middle, Maiden Surname)

LEONIE STREETS

19a. Informant's Name/Relationship (Type, Print)

DOROTHY JOHNSON (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8503 SPRAGUE PLACE, NEW CARROLLTON, MD. 20748

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

PARKLAWN MEMORIAL PARK

Date

8/12/96

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

M859

22. Name and Address of Facility

ALEXANDER S. POPE FUNERAL HOMES

5538 Marlboro Pike, Forestville, Md 20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

b. SQUAMOUS CELL CARCINOMA OF LUNGS.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 month

18 months.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Emphysema

Adenocarcinoma of Prostate.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

MD

29c. License number

D19252

29d. Date signed (Month, Day, Year)

8/8/96.

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ROBERTO A DEPETRIS MD 14300 GALLANT FOX LA #122 BOWIE MD 20715

31. Date filed (Month, Day, Year)

AUG 09 1996

32. Registrar's Signature

Janae...

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit.

10 1/9

110





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25806

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MICHELLE JACKSON

2. Date of Death

Month Day Year  
AUGUST 6 1996

3. Time of Death

07:25A

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

212-82-7369

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

35 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
5-27-61

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Glendale

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1100 Brookland Road

10f. Zip Code

20769

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Robert Butler

18. Mother's Name (First, Middle, Maiden Surname)

Gloria Jackson

19a. Informant's Name/Relationship (Type, Print)

Gloria Hill/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

341 Wyemill Court, Gaithersburg, MD 20879

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dorsey Memorial Cem.

Date

8/10/96

20c. Location - City or Town, State

Glendale, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

J. B. Jenkins Funeral Home

7474 Landover Road, Landover, MD 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Subarachnoid hemorrhage  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acquired Immunodeficiency Syndrome

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

H. Thomas Foley M.D.

29c. License number

D05698

29d. Date signed (Month, Day, Year)

8/7/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

H. Thomas Foley, M.D., Prince George's Hosp. Cen., Cheverly, MD 20785

31. Date filed (Month, Day, Year)

AUG 09 1996

32. Registrar's Signature

John Andrew Carroll

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



96 25807

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Russell Thomas Jackson				2. DATE OF DEATH MONTH 7 DAY 27 YEAR 96		3. TIME OF DEATH 7:25 p.m. M	
4. SOCIAL SECURITY NUMBER 231-50-7396		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 54 YRS.		7. DATE OF BIRTH (Month, Day, Year) 4/6/42	
8. BIRTHPLACE (State or Foreign Country) WASHINGTON, DC				9a. FACILITY NAME (If not institution, give street and number) 6508 8th. Place		9b. CITY, TOWN OR LOCATION OF DEATH Hyattsville	
9c. COUNTY OF DEATH P.G.				10a. STATE MD		10b. COUNTY PG	
10c. CITY, TOWN OR LOCATION BLADENSBURG				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 3801 KENILWORTH AVENUE	
10f. ZIP CODE 20710				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YEARS College (14 or 5+) 2 YEARS				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TRUCK DRIVER		16b. KIND OF BUSINESS/INDUSTRY DRIVING	
17. FATHER'S NAME (First, Middle, Last) WIRT JACKSON SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) MIRIAM NELSON			
19a. INFORMANT'S NAME (Type/Print) VALENTINA BALL JACKSON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS 10A, B, C, D, E, & F			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HARMONY MEMORIAL PARK 8/3/96		20c. LOCATION — City or Town, State LANDOVER, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Juan Smith</i>				22. NAME AND ADDRESS OF FACILITY John T. Rhines & Co. 3030 12th. ST, N.E. Wash., D.C. 20017			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CARCINOMA OF LARYNX Approximate Interval Between Onset and Death 6 months Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>VP Singh Attend Phys</i>				29c. LICENSE NUMBER 0.19897		29d. DATE SIGNED (Month, Day, Year) 8.19.96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) V. SINGH 7209 A HANOVER PARKWAY GREENBELT MD 20770							
31. DATE FILED (Month, Day, Year) AUG 05 1996				32. REGISTRAR'S SIGNATURE <i>John Anderson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25808

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DOROTHY C. JOHNSON

2. Date of Death

Month Day Year  
AUGUST 13, 1996

3. Time of Death

11:00 PM.

4e. Facility Name (If not institution, give street and number)

Prince George Community Hospital

4b. City, Town, or Location of Death

Ceverly, Maryland

4c. County of Death

P.G. County

5. Social Security Number

224-42-5139 A

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 26, 1908

9. Birthplace (State or Foreign Country)

Portsmouth, Va.

Usual Residence of Decedent

10a. State

VA.

10b. County

King George, County

10c. City, Town or Location

12322 Mt. Rose Drive KING GEORGE, VIRGINIA

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street end Number

12322 Mt. ROSE DRIVE King GEORGE, VA.

10f. Zip Code

22485

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

c

4yr.

16e. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

ELEMENTARY SCHOOL TEACHER

16b. Kind of Business/Industry

KING BOARD OF  
EDUCATION

17. Father's Name (First, Middle, Last)

WILEY WILLIAMS

18. Mother's Name (First, Middle, Maiden Surname)

LILLIAN GRIFFIN JOHNSON

19e. Informant's Name/Relationship (Type, Print)

MELVIN L. JOHNSON, SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12322 Mt. ROSE DRIVE KING GEORGE, VA. 22485

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

SALEM BAPTIST CHURCH

Date

8/19/96

20c. Location - City or Town, State

JERSEY, VA.  
KING GEORGE, COUNTY

21. Signature of Funeral Service Licensee

Eugene W. Lee

22. Name and Address of Facility

LEE FUNERAL HOME, INC.

12055 JAMES MADISON PARKWAY KING GEORGE, VA. 22572

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)e. MYOCARDIAL INFARCTION  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28e. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street end Number or Rural Route Number,  
City or Town, State)29e. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

John G. McCoy

29c. License number

D35947

29d. Date signed (Month, Day, Year)

8-14-96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

John G. McCoy 10274 Wake Mabre way #202 Dutchessville Mo.

State  
Registrar

31. Date filed (Month, Day, Year)

AUG 20 1996

32. Registrar's Signature

John Davidson Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25809

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Rudolph

Jones

2. Date of Death

Month August Day 16, 1996 Year

3. Time of Death  
0835

4a. Facility Name (If not institution, give street and number)

Calvert Memorial Hospital

4b. City, Town, or Location of Death

Prince Frederick

4c. County of Death

Calvert

Funeral  
Director

5. Social Security Number

216-06-6444

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 21, 1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Calvert10c. City, Town or Location  
Huntingtown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3955 Hunting Creek Road

10f. Zip Code

20639

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
4

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

William

Jones

18. Mother's Name (First, Middle, Maiden Surname)

Lena

Morsell

19a. Informant's Name/Relationship (Type, Print)

Theo Jones/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3955 Hunting Creek Road Huntingtown, MD 20639

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Church of God Cemetery

Date

8/22/96

20c. Location - City or Town, State

Lothian, MD

21. Signature of Funeral Service Licensee

Spencer E. Sewell

22. Name and Address of Facility

Sewell Funeral Home

1451 Dares Beach Rd. Prince Frederick, MD 20678

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. COMPLICATIONS OF ADVANCED ALZHEIMER'S DISEASE YEARS

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter underlying  
cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

John H. Weiger, M.D.

29c. License number

D 26358  
AUG 28 1996

29d. Date signed (Month, Day, Year)

AUGUST 16, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN H. WEIGER, M.D. - PRINCE FREDERICK MD 20678

31. Date filed (Month, Day, Year)

AUG 19 1996

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

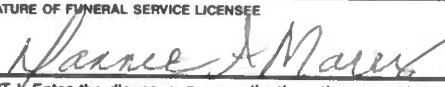
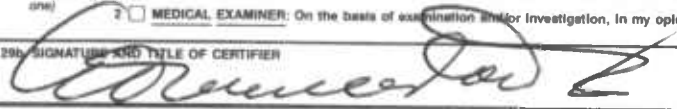
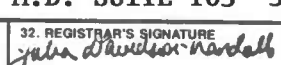




96 25810

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DAVID JOHNSON</b>				2. DATE OF DEATH MONTH <b>AUGUST</b> DAY <b>01</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>3:00 PM</b>	
4. SOCIAL SECURITY NUMBER <b>214-30-8533</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>64 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>JAN 08, 1932</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Berlin Nursing &amp; Rehabilitation Cent.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Berlin</b>		9c. COUNTY OF DEATH <b>Worcester</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Worcester</b>		10c. CITY, TOWN OR LOCATION <b>Snow Hill</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>5152 Spencer Rd</b>				10f. ZIP CODE <b>21863</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>Fifth Grade</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Maintenance Engineer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Showed Poultry</b>			
17. FATHER'S NAME (First, Middle, Last) <b>George Copes</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Beulah Johnson</b>			
19a. INFORMANT'S NAME (Type/Print) <b>John Johnson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5152 Spencer Rd, Snow Hill, MD 21863</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Friendship U.M. Church Cem.</b>		DATE <b>8/6/96</b>		20c. LOCATION — City or Town, State <b>Snow Hill, Md</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>LEWIS N. WATSON FUNERAL HOME</b> <b>1618 West Rd, Salisbury, MD 21801</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>e. END STAGE RENAL DISEASE</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>DIABETIC NEPHROPATHY</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D46257</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/1/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>EDWIN CASTANEDA, M.D. SUITE 103 314 FRANKLIN ST. BERLIN MD 21811</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 05 1996</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25811

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Cheryl Jones</i>		2. Date of Death Month <i>8</i> - Day <i>3</i> - Year <i>96</i>		3. Time of Death <i>8:30 PM</i>
	4e. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>		4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>
Funeral Director	5. Social Security Number <i>216-70-6062</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>37</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>March 20, 1959</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <b>Delaware</b>	10b. County <b>Sussex</b>	10c. City, Town or Location <b>Selbyville</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>Rt 2, Box 87-1</b>		10f. Zip Code <b>19975</b>		10g. Citizen of What Country? <b>United States of Amer.</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th</b> College (1-4 or 5+) <b></b>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nursing Assistant</b>		16b. Kind of Business/Industry <b>Health Care</b>		
	17. Father's Name (First, Middle, Last) <b>James Partlow</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Shirley Purnell</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Irvin Jones? Husband</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Rt 2, Box 87-1, Selbyville, Delaware 19975</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Golden Acres Cemetery</b>		20c. Location - City or Town, State <b>8/10/96 Bishopville, MD</b>
	21. Signature of Funeral Service Licensee <i>Dianne A. Mauer</i>		22. Name and Address of Facility <b>Lewis N. Watson Funeral Home 1618 West Rd, Ext, Salisbury, MD 21801</b>		
Physician /Medical Examiner	23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>Metastatic Breast Cancer</i> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):				Approximate Interval Between Onset and Death <i>3 yrs</i>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
Medical Certification: To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
State Registrar	29b. Signature and title of certifier <i>David E. Carroll MD</i>		29c. License number <b>D28278</b>		29d. Date signed (Month, Day, Year) <b>8-4-96</b>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David E. Carroll, MD 145 E. Carroll St. Salisbury, MD 21801</b>				
31. Date filed (Month, Day, Year) <b>AUG 07 1996</b>		32. Registrar's Signature <i>Julia Anderson-Hardall</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



96 25812

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>CALVIN - - JONES, JR.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>August 4, 1996</b>		3. TIME OF DEATH <b>11:20 A M</b>	
4. SOCIAL SECURITY NUMBER <b>214-28-2906</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>63</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 29, 1932</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>7569 Hayward Road (home)</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Pocomoke City</b>		9c. COUNTY OF DEATH <b>Somerset</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Somerset</b>		10c. CITY, TOWN OR LOCATION <b>Pocomoke City</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>7569 Hayward Road</b>			
10f. ZIP CODE <b>21851</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>Grade 6</b> College (1-4 or 5+) <b>- - -</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Owner</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Meat Packing Co.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Calvin Jones</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Estelle Lee</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Dorothy L. Jones (wife)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7569 Hayward Road - Pocomoke City, MD 21851</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Private Family Cemetery 8/7/96</b>		20c. LOCATION — City or Town, State <b>Pocomoke City, MD</b>		20d. DATE <b>8/7/96</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  <b>Robert H. Bradshaw</b>				22. NAME AND ADDRESS OF FACILITY <b>Bradshaw &amp; Sons Funeral Home 306 W. Main St. - Crisfield, MD 21817</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Lung Cancer</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>MD</b>				29c. LICENSE NUMBER <b>D26278</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-6-96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>David E. Cowall, M.D. - 145 E. Carroll St. - Suite A-1 - Salisbury, MD 21801</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 09 1996</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) AGEEL AHMED KHAN				2. Date of Death Month Day Year JULY 27, 1996		3. Time of Death 16:00 P		
	4a. Facility Name (If not institution, give street and number) SUBURBAN HOSPITAL ER				4b. City, Town, or Location of Death BETHESDA		4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 277-44-5080		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 58 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 7-18-38	9. Birthplace (State or Foreign Country) India	
	Usual Residence of Decedent		10a. State VA		10b. County SPRINGFIELD		10c. City, Town or Location 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 6115 Brandon Ave				10f. Zip Code 22150		10g. Citizen of What Country? USA			
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Indian		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Statistician		16b. Kind of Business/Industry Government			
17. Father's Name (First, Middle, Last) Unavailable				18. Mother's Name (First, Middle, Maiden Surname) Unavailable					
19a. Informant's Name/Relationship (Type, Print) Syed A. Shakeel-Friend				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8009 Daffodil Ct, Springfield, Va 22152					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) George Washington		20c. Date 8-2-96		20d. Location - City or Town, State Adelphi, Maryland		
21. Signature of Funeral Service Licensee <i>Pune A. Matar</i>				22. Name and Address of Facility Universal Mortuary Inc. 411 Kennedy St, N.W.					
23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  e. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Theodore M. King</i> OCME							
29c. License number		29d. Date signed (Month, Day, Year) JULY 31, 1996							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>THEODORE M. KING</i> 111 Penn Street, Baltimore, Maryland 21201								31. Date filed (Month, Day, Year) AUG 05 1996	
32. Registrar's Signature <i>John Andrew Randall</i>									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1992 2 11 1991



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25814

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

EMMA

KENNARD

2. Date of Death

July 28, 1996

3. Time of Death

6:15AM

4a. Facility Name (If not Institution, give street and number)

GLADYS SPELLMAN SPECIALTY HOSPITAL

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

PRINCE GEORGE'S

5. Social Security Number

219-01-0993

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

AUGUST 24, 1903

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

PRINCE GEORGE'S

10c. City, Town or Location

FORESTVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2748 LORRING DRIVE #201

10f. Zip Code

20747

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

3rd

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

COOK

16b. Kind of Business/Industry

PRIVATE

17. Father's Name (First, Middle, Last)

WILLIAM GROSS

18. Mother's Name (First, Middle, Maiden Surname)

EMMA JOANNA

19a. Informant's Name/Relationship (Type, Print)

DORRETHA DADE/NIECE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2748 LORRING DR. #201 FORESTVILLE, MD 20747

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

LINCOLN CEMETERY

Data

AUG. 5

20c. Location - City or Town, State

SUITLAND, MARYLAND

21. Signature of Funeral Service Licensee

Guawana L. Braxton

22. Name and Address of Facility

MARSHALL'S FUNERAL HOME

4308 SUITLAND ROAD SUITLAND, MD 20746

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

b. STROKE

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

&gt;2-monthly

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

APHASIA; DYSPHAGIA;

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

S. J. Rao

29c. License number

D-34525

29d. Date signed (Month, Day, Year)

07-28-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. J. Rao, MD; 4000-Mitchellville Road # 220; Bowie, MD 20716.

31. Date filed (Month, Day, Year)

AUG 06 1996

32. Registrar's Signature

John Andrew Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WILLIAM J. BRYAN

დასკვნა

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25815

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>John J. Kshimetski</u>						2. Date of Death Month <u>August</u> Day <u>10<sup>th</sup></u> Year <u>96</u>		3. Time of Death <u>04:20 AM</u>	
	4a. Facility Name (If not institution, give street and number) <u>308 Green Drive</u>						4b. City, Town, or Location of Death <u>Pasadena</u>		4c. County of Death <u>Anne Arundel</u>	
Funeral Director	5. Social Security Number <u>084-12-4425</u>		6. Sex <u>1</u> M <u>2</u> F		7. Age (In yrs. last birthday) <u>75</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>April 28 1921 NY</u>		9. Birthplace (State or Foreign Country)	
	Usual Residence of Decedent									
10a. State <u>MD</u>		10b. County <u>Anne Arundel</u>		10c. City, Town or Location <u>Pasadena</u>				10d. Inside City Limits <u>1</u> Yes <u>2</u> No		
10e. Street and Number <u>308 Green Drive</u>				10f. Zip Code <u>21122</u>		10g. Citizen of What Country? <u>USA</u>				
11. Marital Status <u>1</u> Never Married <u>2</u> Married <u>3</u> Widowed <u>4</u> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <u>1</u> Yes <u>2</u> No If Yes, Give Year or Dates: <u>38-65</u>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <u>1</u> Yes <u>2</u> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>White</u>		
15. Decedent's Education (Specify only highest grade completed) <u>Elementary/Secondary (0-12)</u> <u>12</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>US Navy</u>			16b. Kind of Business/Industry <u>Military</u>			
17. Father's Name (First, Middle, Last) <u>Unknown</u>						18. Mother's Name (First, Middle, Maiden Surname) <u>Unknown</u>				
19a. Informant's Name/Relationship (Type, Print) <u>Ann L. Kshimetski / wife</u>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>308 Green Drive Pasadena MD. 21122</u>				
20a. Method of Disposition <u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State <u>4</u> Donation <u>5</u> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <u>MD Veterans Cemetery</u>		Data <u>8/14</u>		20c. Location - City or Town, State <u>Crownsville, MD</u>		
21. Signature of Funeral Service Licensee <u>[Signature]</u>				22. Name and Address of Facility <u>Barranco &amp; Sons Funeral Home</u> <u>495 Ritchie Hwy Severna Park, MD. 21146</u>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <u>Progression of Lung Carcinoma</u> <u>Metastatic lung carcinoma</u>										
Immediate Cause (Final disease or condition resulting in death)  <u>3 months</u>  <u>11 months</u>										
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  c. d.										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <u>1</u> Yes <u>2</u> No <u>3</u> Probably <u>4</u> Unknown		
								24a. Was an autopsy performed? <u>1</u> Yes <u>2</u> No		
								24b. Were autopsy findings available prior to completion of cause of death? <u>1</u> Yes <u>2</u> No		
25. Was case referred to medical examiner? <u>1</u> Yes <u>2</u> No				26. Place of Death (Check only one) Hospital: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA Other: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify)						
27. Manner of Death <u>1</u> Natural <u>5</u> Pending Investigation <u>2</u> Accident <u>6</u> Could not be determined <u>3</u> Suicide <u>4</u> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <u>1</u> Yes <u>2</u> No		
				28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how Injury occurred		
				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <u>2</u> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <u>Gayatri Nimmagadda</u>										
				29c. License number <u>D39041</u>		29d. Date signed (Month, Day, Year) <u>August 12<sup>th</sup> 1996</u>				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <u>GAYATRI NIMMAGADDA</u> <u>1600 S Crain Hwy</u> <u>Ste 602</u> <u>MD 21061</u>										
31. Date filed (Month, Day, Year) <u>AUG 15 1996</u>				32. Registrar's Signature <u>[Signature]</u>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

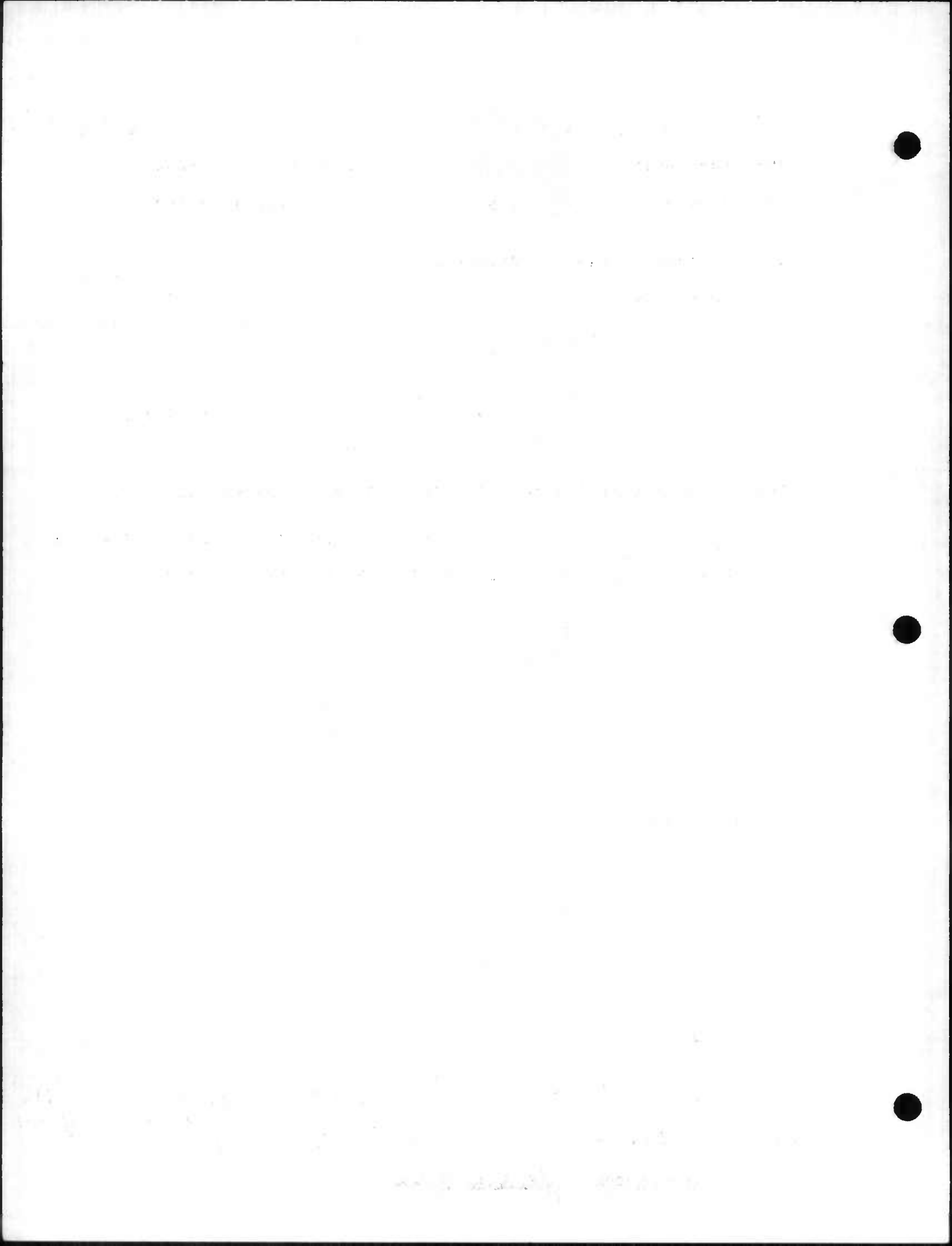
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25816

## Certificate of Death

Reg. No.

Amended # 4c.P.G.C 8-6-96 CR

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DEBORAH LOCKHART

2. Date of Death

Month Day Year

July 26 1996

3. Time of Death

10:30PM

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery Prince Georges

Funeral  
Director

5. Social Security Number

239-60-3458

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

60

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
10-19-35

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10e. State

D. C.

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4212 8th Street, N. W.

10f. Zip Code

20011

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)  
5+

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Librarian

16b. Kind of Business/Industry

DC Library

17. Father's Name (First, Middle, Last)

Milton Roberson

18. Mother's Name (First, Middle, Maiden Surname)

Willie Ethel Wyche

19. Informant's Name/Relationship (Type, Print)

Tracie Lockhart (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4212 8th Street NW Washington DC 20011

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Md. National Mem. Pk 8-1-96 Laurel, Md.

Date

20c. Location - City or Town, State

Marshall's Funeral Home Inc  
4217 9th Street, N. W.  
Washington, D. C. 20011

21. Signature of Funeral Service Licensee

J. P. Marshall

22. Name and Address of Facility

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Rupture

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Diabetes Mellitus

Due to (or as a consequence of):

d.

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☒ Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural  
☐ Accident  
☐ Suicide  
☐ Homicide☐ Pending investigation  
☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Luther A. Virgil, MD

29c. License number

18669

29d. Date signed (Month, Day, Year)

7/31/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Luther A. Virgil, MD 1160 Varnum St. N.E. #317 Washington D.C.

31. Date filed (Month, Day, Year)

AUG 06 1996

32. Registrar's Signature

John M. ...

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25817

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Harold Logan</b>				2. Date of Death Month <b>August</b> Day <b>1</b> Year <b>1996</b>				3. Time of Death <b>8:56 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Holy Cross Hospital</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>				4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>237-48-1706</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>63</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov 16, 1932</b>		9. Birthplace (State or Foreign Country) <b>Old Fort, NC</b>	
	Usual Residence of Decedent									
10a. State <b>DC</b>		10b. County		10c. City, Town or Location <b>Washington</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>5312 Chillum Place N.E.</b>				10f. Zip Code <b>20011</b>				10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1953-1955</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12th</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Supervisor</b>				16b. Kind of Business/Industry <b>US Soldiers Home</b>		
17. Father's Name (First, Middle, Last) <b>Luther Logan, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lucy Lytle</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Alice Logan - Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5312 Chillum Place N.E. Wash DC 20011</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Ft. Lincoln Cemetery</b>		Date <b>8-6-96</b>		20c. Location - City or Town, State <b>Brentwood, MD</b>		
21. Signature of Funeral Service Licensee <b>J. P. Marshall</b>				22. Name and Address of Facility <b>Marshall's Funeral Home, Inc. 4217 9th St. NW, Wash DC 20011</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Acute Renal failure.</b> Due to (or as a consequence of): <b>b. Lymphoma</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>								Approximate Interval Between Onset and Death <b>3 days</b> <b>1 1/2 years</b>		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
				28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>Amenduratta MD</b>				29c. License number <b>D38262</b>		
				29d. Date signed (Month, Day, Year) <b>Aug 14 1996</b>						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR MENDURATTA 40 KAISER, HCH 1500 forest Glen Road Silver Spring MD</b>										
31. Date filed (Month, Day, Year) <b>AUG 06 1996</b>				32. Registrar's Signature <b>J. Andrew Ruskell</b>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25818

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Stanley Curtis Leslie

2. Date of Death

Month Day Year  
August 7, 1996

3. Time of Death

2:45am

4a. Facility Name (If not institution, give street and number)

5809 Kentucky Ave

4b. City, Town, or Location of Death

District Heights

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

065-14-9776

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
Nov 1, 1922

9. Birthplace (State or Foreign Country)

Gloverville NY

Usual Residence of Decedent

10e. State  
Maryland  
10b. County  
Prince Georges  
10c. City, Town or Location  
District Heights

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

5809 Kentucky Ave

10f. Zip Code

20747

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No  
If Yes, Give Year or Dates: 1942-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Computer Repaireman

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Clarence Leslie

18. Mother's Name (First, Middle, Maiden Surname)

Katherine Huskins

19a. Informant's Name/Relationship (Type, Print)

Robert Leslie / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2904 Millvale Ave Forestville Maryland 20747

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Northville Cemetery

Date

8/10/96

20c. Location - City or Town, State

Northville NY

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Alexander S. Pope Funeral Homes  
5538 Marlboro Pike Forestville Maryland 20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Angiosarcoma of The Face

Due to (or as a consequence of):

b. Ischemic Heart Disease

Due to (or as a consequence of):

c. Chronic Abstructive Lung Disease

Due to (or as a consequence of):

d. Hypertensive Cardiovascular Disease

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D12863

29d. Date signed (Month, Day, Year)

August 7, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr Hassan A. Molavi 6005 Landover Rd Cheverly Maryland 20785

31. Date filed (Month, Day, Year)

AUG 09 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25819

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

FERN A. LANTHIER

2. Date of Death

Month Day Year  
AUGUST 3 1996

3. Time of Death

6:25 A.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

13506 Youngwood Turn

4b. City, Town, or Location of Death

Bowie

4c. County of Death

Prince Georges

5. Social Security Number

183-30-5180

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

57

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
December 1, 1938

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Bowie

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

13506 Youngwood Turn

10f. Zip Code

20715

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Systems Analyst

16b. Kind of Business/Industry

Computer

17. Father's Name (First, Middle, Last)

Peter Robine

18. Mother's Name (First, Middle, Maiden Surname)

Genevieve Bodenshatz

19a. Informant's Name/Relationship (Type, Print)

Robert Lanthier / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13506 Youngwood Turn Bowie, Maryland 20715

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

St. Mary's Cemetery

Date

8-7-96 New Germany, Pennsylvania

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Robert E. Evans, Pres.

22. Name and Address of Facility

Robert E. Evans Funeral Home, P.A.

16000 Annapolis Road Bowie, Maryland 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC ADENOCARCINOMA

10 MONTHS

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

E. W. Cole III MD

29c. License number

D16354

29d. Date signed (Month, Day, Year)

AUGUST 3, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

E-W. COLE III 900 BESTGATE RD ANNAP MD 21401

31. Date filed (Month, Day, Year)

AUG 09 1996

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

15



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25820

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Christine O. Langley

2. Date of Death

JULY 30, 1996

3. Time of Death

6:30PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

4401 RIDGECREST DRIVE

4b. City, Town, or Location of Death

SUITLAND

4c. County of Death

PRINCE GEORGE'S

5. Social Security Number

579-56-7701

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

.52 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

AUGUST 8, 1943

9. Birthplace (State or Foreign Country)

WASHINGTON, DC

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

PRINCE GEORGE'S

10c. City, Town or Location

SUITLAND

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4401 RIDGECREST DRIVE

10f. Zip Code

20746

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

EDITOR

16b. Kind of Business/Industry

FEDERAL GOVT.

17. Father's Name (First, Middle, Last)

HOWARD BROWN

18. Mother's Name (First, Middle, Maiden Surname)

MILDRED OLIPHANT

19a. Informant's Name/Relationship (Type, Print)

MILDRED PURCE BROWN/ MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1612 FORT DUPONT ST. SE WASHINGTON, DC 20020

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

CEDAR HILL CEMETERY

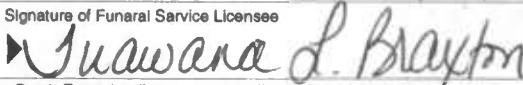
Date

8/2/96

20c. Location - City or Town, State

SUITLAND, MARYLAND

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

MARSHALL'S FUNERAL HOME  
4308 SUITLAND RD SUITLAND, MD 20746

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. METASTATIC COLON CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

2 1/2 YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

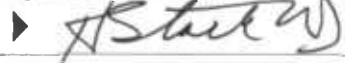
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

DC17019

29d. Date signed (Month, Day, Year)

AUGUST 1, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. HOWARD A. STARK, MD 2311 M ST NW SUITE 302 WASHINGTON, DC 20037

31. Date filed (Month, Day, Year)

AUG 06 1996

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25821

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

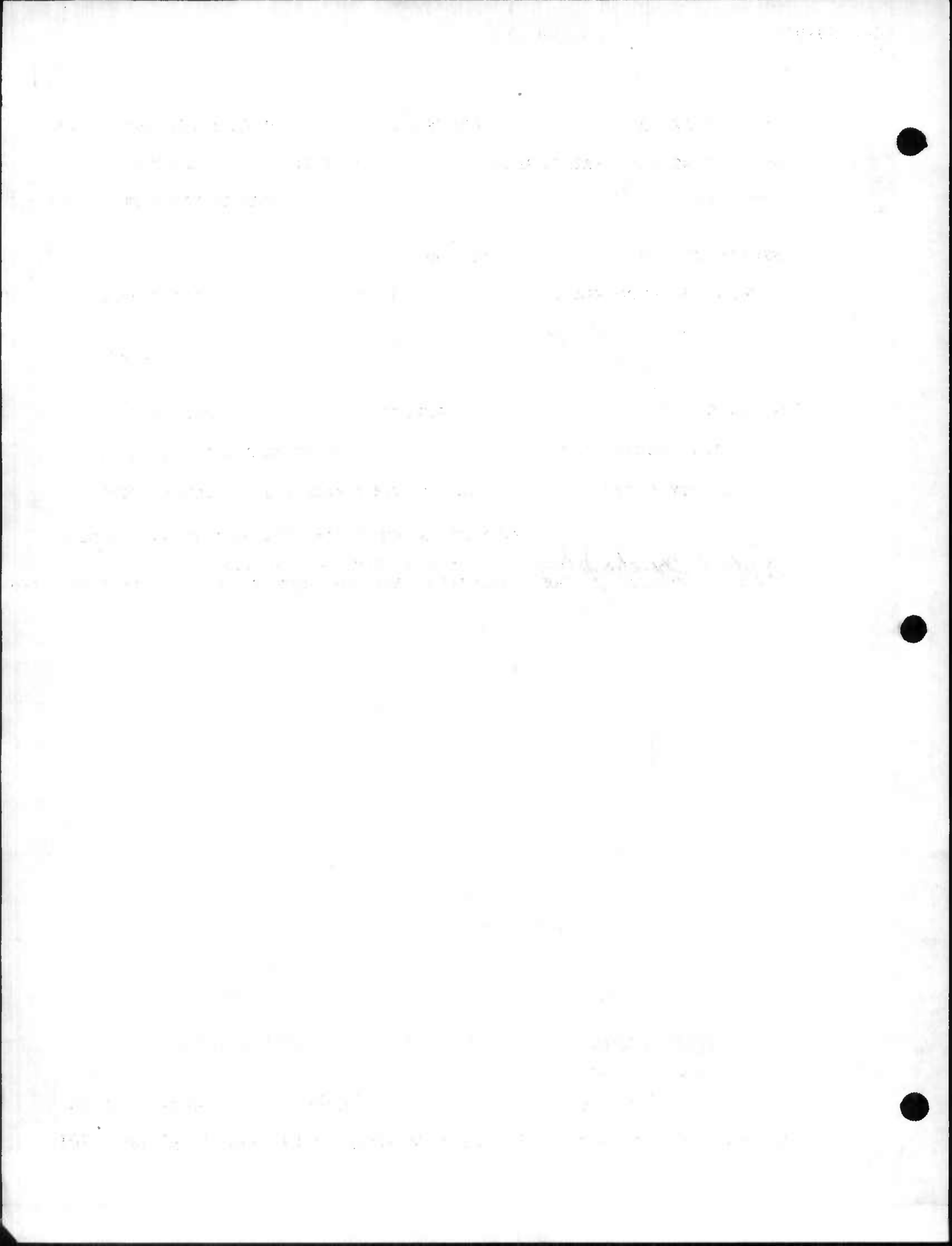
Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>FREDERICK A LANCASTER 11</b>				2. Date of Death Month Day Year <b>AUGUST 17, 1996</b>		3. Time of Death <b>03:20 A</b>	
4a. Facility Name (If not institution, give street and number) <b>PHYSICIANS MEMORIAL HOSPITAL</b>				4b. City, Town, or Location of Death <b>LA PLATA</b>		4c. County of Death <b>CHARLES</b>	
5. Social Security Number <b>212-84-9622</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>36</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>APRIL 11, 1960</b>	
9. Birthplace (State or Foreign Country) <b>WASHINGTON, D.C.</b>		10a. State <b>MARYLAND</b>		10b. County <b>CHARLES</b>		10c. City, Town or Location <b>INDIAN HEAD</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>#6950 HARGROVE PLACE</b>		10f. Zip Code <b>20640</b>		10g. Citizen of What Country? <b>UNITED STATES</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH GRADE</b> College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MECHANIC</b>		16b. Kind of Business/Industry <b>AUTOMOTIVE</b>			
17. Father's Name (First, Middle, Last) <b>FREDERICK A. LANCASTER SR.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MARJORIE THOMAS LANCASTER</b>			
19a. Informant's Name/Relationship (Type, Print) <b>CECILIA PERRY / WIFE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. BOX #734 BRYANS ROAD, MARYLAND 20616</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>METROPOLITAN CHURCH CEM.</b>		20c. Location - City or Town, State <b>8/22/96 POMONKEY, MARYLAND</b>			
21. Signature of Funeral Service Licensee <i>Lydia C. Thornton Johnson</i>				22. Name and Address of Facility <b>THORNTON FUNERAL HOME, P.A. 1111 DIA C. THORNTON JOHNSON MO0583#3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Head Injuries</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>8-17-96</b>		28b. Time of Injury <b>02:27 M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28d. Describe how injury occurred <b>COLLISION</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Roadway</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Livingston Rd</b>	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>OCME</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 17, 1996</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>							
31. Date filed (Month, Day, Year) <b>AUG 20 1996</b>				32. Registrar's Signature <i>[Signature]</i>			

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25822

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RICHARD EDWARD LEWIS			2. Date of Death Month Day Year July 31, 1996		3. Time of Death 12: 15 PM	
	4a. Facility Name (If not institution, give street and number) Salisbury Center; Genesis ElderCare			4b. City, Town, or Location of Death Salisbury, Md.		4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 220-16-9847	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 14, 1926	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State Maryland	10b. County Wicomico	10c. City, Town or Location Salisbury		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10a. Street and Number 418 Midland Terrace		10f. Zip Code 21801		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 Collage (1-4or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanic		16b. Kind of Business/Industry Automotive		
	17. Father's Name (First, Middle, Last) Ira James Lewis			18. Mother's Name (First, Middle, Maiden Surname) Mary Elizabeth Jarman			
	19a. Informant's Name/Relationship (Type, Print) Betty J. Lewis/spouse			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 418 Midland Terrace, Salisbury, MD 21801			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Wicomico Memorial Park		Date 8/3/96	20c. Location - City or Town, State Salisbury, MD	
	21. Signature of Funeral Service Licensee <i>John M. Salisbury</i>			22. Name and Address of Facility Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804			
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Complications of Advanced Parkinson's</i> Due to (or as a consequence of): <i>And Dementia</i>					Approximate Interval Between Onset and Death <i>years</i>	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>Pressure Sore Buttocks</i> <i>Peptic Ulcer Disease</i>						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <i>Michael D. Atkins MD</i>			29c. License number D-39813		29d. Date signed (Month, Day, Year) 8/1/96		
30. Name and address of person who completed cause of death (item 23a) (Type, Print) M Atkins MD 1104 HEALTHWAY DR., SALISBURY, Md.							
31. Date filed (Month, Day, Year) AUG 02 1996			32. Registrar's Signature <i>Julia Davidson Hardell</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Amended #1 AH

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25823

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>RAYMOND DELEAR LOCHNER</b>				2. Date of Death Month <b>Aug</b> Day <b>14</b> Year <b>96</b>		3. Time of Death <b>1615</b>		
	4a. Facility Name (If not institution, give street and number) <b>GENESIS ELDERCARE, 35 MILKSPRING LN</b>				4b. City, Town, or Location of Death <b>ANNAPOLIS</b>		4c. County of Death <b>ANNE ARUNDEL</b>		
Funeral Director	5. Social Security Number <b>552-26-8691</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>72</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Dec 3, 1923</b>		9. Birthplace (State or Foreign Country) <b>California</b>
	Usual Residence of Decedent								
10a. State <b>MD</b>			10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Annapolis</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>1890 Luce Creek Drive</b>				10f. Zip Code <b>21401</b>		10g. Citizen of What Country? <b>United States</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>WWII &amp;</b> If Yes, Give Year or Dates: <b>Korea</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Engineer</b>			16b. Kind of Business/Industry <b>US Navy &amp; Logistics/ Private</b>		
17. Father's Name (First, Middle, Last) <b>Lodia DeLear Lochner</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Robertson</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Jean T. Lochner-Wife</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1890 Luce Creek Drive Annapolis, Maryland 21401</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Ft. Lincoln Crematory</b>		Date <b>8/16/96</b>		20c. Location - City or Town, State <b>Brentwood, Maryland</b>		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. <u>WIDELY METASTATIC Ca PROSTATE</u></b> Due to (or as a consequence of):  <b>b. _____</b> Due to (or as a consequence of):  <b>c. _____</b> Due to (or as a consequence of):  <b>d. _____</b>  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death <b>6 mos</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier 					29c. License number <b>D 21438</b>		29d. Date signed (Month, Day, Year) <b>8.14.96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MICHAEL J. LAPEN MD 600 RIDGELY AVE STE 120 ANNAPOLIS MD 21401</b>									
31. Date filed (Month, Day, Year) <b>AUG 16 1996</b>			32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25824

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CHARLES I. LEWIS</b>				2. Date of Death Month Day Year <b>Aug. 4, 1996</b>		3. Time of Death <b>1320 Hrs.</b>							
	4a. Facility Name (If not institution, give street and number) <b>Peninsula Regional Medical Center</b>				4b. City, Town, or Location of Death <b>Salisbury</b>		4c. County of Death <b>Wicomico</b>							
Funeral Director	5. Social Security Number <b>217-16-9125</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>72</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct. 16, 1923</b>							
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Md.</b>		10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Fruitland</b>							
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>201 W. Main St.</b>		10f. Zip Code <b>21826</b>		10g. Citizen of What Country? <b>U.S.A.</b>							
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>W.W. II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Excavator Owner &amp; Operator</b>		16b. Kind of Business/Industry <b>Construction</b>									
	17. Father's Name (First, Middle, Last) <b>Raymond S. Lewis</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Hazel May Johnson</b>									
	19a. Informant's Name/Relationship (Type, Print) <b>Charles R. Lewis</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>27 Old Fence Lane, Newark, Del. 19702</b>									
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Spring Hill Mem. Gdns.</b>		Data <b>8/7/96</b>		20c. Location - City or Town, State <b>Hebron, Md.</b>							
	21. Signature of Funeral Service Licensee <i>Gerald C. Bunker</i>				22. Name and Address of Facility <b>Bounds Funeral Home, Salisbury, Md. 21801</b>									
	23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
	<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a. <b>Myocardial Infarction</b> Due to (or as a consequence of):</td> <td rowspan="4">           Approximate Interval Between Onset and Death   <b>less than one hour</b>   <b>more than 10 yrs.</b>   <b>more than 15 yrs</b> </td> </tr> <tr> <td>b. <b>Atherosclerotic Vascular ds.</b> Due to (or as a consequence of):</td> </tr> <tr> <td>c. <b>Hypertension</b> Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <b>Myocardial Infarction</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death  <b>less than one hour</b>  <b>more than 10 yrs.</b>  <b>more than 15 yrs</b>	b. <b>Atherosclerotic Vascular ds.</b> Due to (or as a consequence of):	c. <b>Hypertension</b> Due to (or as a consequence of):	d.
	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <b>Myocardial Infarction</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death  <b>less than one hour</b>  <b>more than 10 yrs.</b>  <b>more than 15 yrs</b>											
b. <b>Atherosclerotic Vascular ds.</b> Due to (or as a consequence of):														
c. <b>Hypertension</b> Due to (or as a consequence of):														
d.														
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Obstructive Pulmonary Disease</b> <b>Pulmonary Fibrosis</b>														
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown														
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)														
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined														
28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
28d. Describe how injury occurred 28e. Location (Street and Number or Rural Route Number, City or Town, State)														
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.														
29b. Signature and title of certifier <i>[Signature]</i>														
29c. License number <b>D24986</b>														
29d. Date signed (Month, Day, Year) <b>8/5/96</b>														
30. Name and address of person who completed Cause of death (Item 23a) (Type, Print) <b>Robert J. Reilly mo 106 Mifflin St Salisbury md. 21801</b>														
31. Date filed (Month, Day, Year) <b>AUG 06 1996</b>														
32. Registrar's Signature <i>John Davidson Randall</i>														

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the document is a list of names and addresses.

2. The second part of the document is a list of names and addresses.

3. The third part of the document is a list of names and addresses.

4. The fourth part of the document is a list of names and addresses.

5. The fifth part of the document is a list of names and addresses.

6. The sixth part of the document is a list of names and addresses.

7. The seventh part of the document is a list of names and addresses.

8. The eighth part of the document is a list of names and addresses.

9. The ninth part of the document is a list of names and addresses.

10. The tenth part of the document is a list of names and addresses.

11

12

13

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20

21. The last part of the document is a list of names and addresses.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25825

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JESSE

J.

MATTHEWS, JR.

2. Date of Death

AUGUST 04 1996

3. Time of Death

11:30 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

4142 BUNKER HILL ROAD #304

4b. City, Town, or Location of Death

HYATTSVILLE

4c. County of Death

PRINCE GEORGES

5. Social Security Number

220-12-3291

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

69

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

12/22/26

9. Birthplace (State or Foreign Country)

N. Carolina

Usual Residence of Decedent

10a. State

Md.

10b. County

P.G.

10c. City, Town or Location

Cottage City

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4142 Bunker Hill Rd. # 304

10f. Zip Code

20722

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

7th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Mt. Rainier City  
Government

17. Father's Name (First, Middle, Last)

Jesse J. Matthews, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Nellie Darden

19a. Informant's Name/Relationship (Type, Print)

Elizabeth E. Matthews/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Sameas # 10 above

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Lincoln Mem. Cem. 8/10/96

Date

20c. Location - City or Town, State

Suitland, Md.

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

H.S. Washington & Sons, inc.  
4925 Burroughs Ave., N.E.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

Hypertensive Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC ALCOHOLISM

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending

Investigation

☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

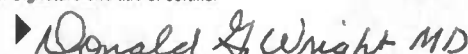
Work?

☐ Yes ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☐ Certifying Physician:☒ Medical Examiner:To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier



29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

AUGUST 05, 1996

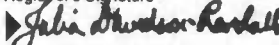
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Donald G. Wright M.D. 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 08 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show  
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once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner






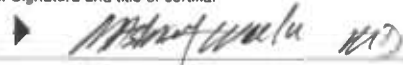
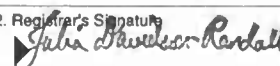
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25826

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Frank Latham McAlwee Sr</b>		2. Date of Death Month <b>August</b> Day <b>16</b> Year <b>1996</b>		3. Time of Death <b>0600 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>Calvert Memorial Hospital</b>		4b. City, Town, or Location of Death <b>Prince Frederick</b>		4c. County of Death <b>Calvert</b>
Funeral Director	5. Social Security Number <b>448-03-4262</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>NOV 1 1913</b>		9. Birthplace (State or Foreign Country) <b>Washington, DC</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <b>Maryland</b>	10b. County <b>St Mary's</b>	10c. City, Town or Location <b>Charlotte Hall</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>Charlotte Hall Veterans Home Rt 2 Box 5</b>		10f. Zip Code <b>20622</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW 11</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Printer</b>		16b. Kind of Business/Industry <b>US Government</b>		
	17. Father's Name (First, Middle, Last) <b>Frank Mc Alwee</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Florine Mc Alwee</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Audrey B. Mc Alwee (Wife)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>23001 Neck Road Aquasco, Maryland 20608</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Maryland Veterans Cem.</b>		20c. Location - City or Town, State <b>8-20-96 Cheltenham, MD</b>
	21. Signature of Funeral Service Licensee  <b>M00173</b>		22. Name and Address of Facility <b>J.H. Eberwein Mortuary 4433 White Pls La White Pls., MD 20695</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Cardiopulmonary arrest</b> Due to (or as a consequence of): <b>b. pneumonia</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>4 min</b> <b>2 weeks</b>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day Year)					
28b. Time of Injury <b>M</b>					
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No					
28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier  <b>MD</b>					
29c. License number <b>D 462 46</b>					
29d. Date signed (Month, Day, Year) <b>August 18, 1996</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Meelu Prince Frederick, MD. 20678</b>					
31. Date filed (Month, Day, Year) <b>AUG 19 1996</b>					
32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended #14, P.G. 6C.

State of Maryland / Department of Health and Mental Hygiene

96 25827

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James J. Minor				2. Date of Death Month 07 Day 30 Year 96				3. Time of Death 3:45pm		
	4a. Facility Name (If not institution, give street and number) 2513 Larry Avenue				4b. City, Town, or Location of Death Ft. Washington				4c. County of Death PG		
Funeral Director	5. Social Security Number 228-44-9858		8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 60 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		
	6. Date of Birth (Month, Day, Year) 08/31/35		9. Birthplace (State or Foreign Country) NC		10. Usual Residence of Decedent 10a. State MD 10b. County P.G. 10c. City, Town or Location FT. Washington 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 2413 Larry Ave.		10f. Zip Code 20744		
To Be Completed by Funeral Director		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1961-1964		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)	
		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Communication Spec.		16b. Kind of Business/Industry Federal Government		17. Father's Name (First, Middle, Last) Stephen Minor		18. Mother's Name (First, Middle, Maiden Surname) Clara Wilson		19. Informant's Name/Relationship (Type, Print) Elizabeth Minor	
Physician /Medical Examiner		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		Date 8/5/96		20c. Location - City or Town, State Suitland, Md.		21. Signature of Funeral Service Licensee <u>James Edwards</u>	
		22. Name and Address of Facility Hodges and Edwards 3910 Silver Hill RD. Suitland, Md. 20746		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>Acute Myocardial Infarction</u> Due to (or as a consequence of): <u>ASCD</u> Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		Approximate Interval Between Onset and Death <u>immed</u>		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
Medical Certification: To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
State Registrar		29b. Signature and name of certifier <u>Frank M. Reynolds</u>		29c. License number D19431		29d. Date signed (Month, Day, Year) 8/2/96		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Frank M. Reynolds 11701 Livingston Rd #203, Ft. Washington MD 20744		31. Date filed (Month, Day, Year) AUG 09 1996	
		32. Registrar's Signature <u>John Hunter-Karhoff</u>									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25828

Amended # 5. P.G.C. 8-16-96 CR

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CAROL

B.

McLAURIN

2. Date of Death  
Month Day Year

Aug. 2, 1996

3. Time of Death

3:00 AM

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

243-48-0994

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

60

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

March 15, 1936

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Camp Springs

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6610 Howie Court

10f. Zip Code

20748

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Raymond Roosevelt Riley

18. Mother's Name (First, Middle, Maiden Surname)

Lily Austin

19a. Informant's Name/Relationship (Type, Print)

William J. McLaurin/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6610 Howie Ct. Camp Springs, Md. 20748

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

8/8/96 Date

Rieves Chapel Bapt. Church Cem. Siler City, N. Carolina

20c. Location - City or Town, State

Siler City, N. Carolina

21. Signature of Funeral Service Licensee

Robert O. Kalas

22. Name and Address of Facility

George P. Kalas Funeral Home

6160 Oxon Hill Rd. Oxon Hill, Md. 20745

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Ca. of breast (Poorly differentiated Infiltrating Ductal Ca.)

b. Acute renal failure (ATN)

c. Hypertensive heart disease

d. Malignant pleural effusion

Morbid obesity

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M. Saeed Koolae, M.D.

29c. License number

D46260

29d. Date signed (Month, Day, Year)

Aug. 2, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. SAEED KOOLAE, M.D. 6188 Oxon Hill Rd. Oxon Hill Md. 20745

31. Date filed (Month, Day, Year)

AUG 05 1996

32. Registrar's Signature

John Davidson

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

15



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25829

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Alice LOUISE BROWN Mathis			2. Date of Death Month Day Year August 17 1996		3. Time of Death 4:16 PM	
	4a. Facility Name (If not Institution, give street and number) Physicians Memorial Hospital			4b. City, Town, or Location of Death La Plata		4c. County of Death Charles	
Funeral Director	5. Social Security Number 220-32-3758		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 61 Yrs.	8. Date of Birth (Month, Day, Year) JULY 6, 1935		9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County CHARLES		10c. City, Town or Location WHITE PLAINS		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number #3815 KAHLER ROAD			10f. Zip Code 20695		10g. Citizen of What Country? UNITED STATES	
To Be Completed by Physician/Medical Examiner	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ YEARS		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CHIEF FINANCE OFFICER		16b. Kind of Business/Industry U.S. DEPT. OF DEFENSE GOVERNMENT		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) PAUL LOUIS BROWN			18. Mother's Name (First, Middle, Maiden Surname) FRANCIS LOUISE HAMMOND BROWN			
	19a. Informant's Name/Relationship (Type, Print) ANDRE MATHIS / SON			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #3360 JAVA PLUM AVENUE, MIRAMAR, FLORIDA 33025			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HUNTT CREMATORY		Date 8/23/96		20c. Location - City or Town, State WALDORF, MARYLAND
	21. Signature of Funeral Service Licensee Lydia C. Thornton Johnson LYDIA C. THORNTON JOHNSON M00583		22. Name and Address of Facility THORNTON FUNERAL HOME, P.A. #3439 LIVINGSTON ROAD, INDIAN HEAD, MD. 20640				
To Be Completed by Physician/Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Massive Subarachnoid Hemorrhage Due to (or as a consequence of): Systemic Vasculitis Due to (or as a consequence of): Chronic Renal Failure Due to (or as a consequence of): Bilateral Pulmonary Pneumonia						Approximate Interval Between Onset and Death
	23a. Part 2. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Anaemia, Thrombocytopenia						
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) as stated.		29b. Signature and title of certifier Mishra		29c. License number D-23021		29d. Date signed (Month, Day, Year) 8/18/96
	30. Name and address of person who completed cause of death (item 23a) (Type, Print) Sanjeeb Mishra, MD Cerna Medical Cntr 7-C Post Office Rd. Waldorf, Md. 20602						
State Registrar	31. Date filed (Month, Day, Year) AUG 20 1996		32. Registrar's Signature Julia Swanson Randall				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





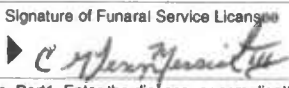

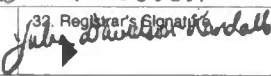
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25830

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Harry Morris</b>			2. Date of Death Month <b>August</b> Day <b>8</b> Year <b>1996</b>			3. Time of Death <b>1220</b>				
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>			4b. City, Town, or Location of Death <b>SALISBURY</b>			4c. County of Death <b>WICOMICO</b>				
Funeral Director	5. Social Security Number <b>216-16-9063A</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>74</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>5-26-1922</b>		9. Birthplace (State or Foreign Country) <b>Md.</b>		
	10a. State <b>Md.</b>			10b. County <b>Wicomico</b>			10c. City, Town or Location <b>Salisbury</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>6437 MARY Jane Drive</b>			10f. Zip Code <b>21801</b>			10g. Citizen of What Country? <b>USA</b>				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW11</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+) <b>College</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Retail Sales</b>			16b. Kind of Business/Industry <b>Beachnut Packing</b>				
	17. Father's Name (First, Middle, Last) <b>Harry V. Heath</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Marie Morris</b>							
	19a. Informant's Name/Relationship (Type, Print) <b>Marguerite Heath</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6437 Mary Jane Drive Salisbury 21801</b>							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Springhill Mem. Garden</b>			20c. Location - City or Town, State <b>8-12-96 Hebron, Md.</b>				
	21. Signature of Funeral Service Licensee  <b>M00416</b>			22. Name and Address of Facility <b>Messick Funeral Home PO 61 Bivalve, Md. 21814</b>							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Acute Congestive Heart Failure</b> Due to (or as a consequence of): b. <b>Ischemic Heart Disease</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			Approximate Interval Between Onset and Death <b>1-2 hrs.</b>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>- Diabetes</b> <b>- Peripheral Vascular Insufficiency</b>			23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier  <b>MD</b>			29c. License number <b>D 23756</b>			29d. Date signed (Month, Day, Year) <b>8-8-96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JOHN BARTKOVICH</b> <b>45 E. CARROLL ST. SALIS MD.</b>											
31. Date filed (Month, Day, Year) <b>AUG 13 1996</b>			32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1. The first part of the report is devoted to a general survey of the situation in the country.

2. The second part of the report is devoted to a detailed analysis of the economic situation.

3. The third part of the report is devoted to a detailed analysis of the social situation.

4. The fourth part of the report is devoted to a detailed analysis of the political situation.

5. The fifth part of the report is devoted to a detailed analysis of the cultural situation.

6. The sixth part of the report is devoted to a detailed analysis of the international situation.

7. The seventh part of the report is devoted to a detailed analysis of the future prospects.

8. The eighth part of the report is devoted to a detailed analysis of the conclusions.

9. The ninth part of the report is devoted to a detailed analysis of the recommendations.

10. The tenth part of the report is devoted to a detailed analysis of the annexes.

11. The eleventh part of the report is devoted to a detailed analysis of the bibliography.

12. The twelfth part of the report is devoted to a detailed analysis of the index.

13. The thirteenth part of the report is devoted to a detailed analysis of the appendices.

14. The fourteenth part of the report is devoted to a detailed analysis of the conclusions.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25831

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ethel Elizabeth Carroll Myers				2. Date of Death Month Day Year June 15, 1996		3. Time of Death 4:00 p.m.	
	4a. Facility Name (If not institution, give street and number) 23440 Handy Point Road (At Home)				4b. City, Town, or Location of Death Chestertown		4c. County of Death Kent	
Funeral Director	5. Social Security Number 216-80-8446		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) February 7, 1928	
	9. Birthplace (State or Foreign Country) Templeville, DE							
Usual Residence of Decedent								
10a. State Maryland		10b. County Kent		10c. City, Town or Location Chestertown				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
10e. Street and Number 23440 Handy Point Road				10f. Zip Code 21620		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 6				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Domestic/Own Home	
17. Father's Name (First, Middle, Last) Theodore Carroll				18. Mother's Name (First, Middle, Maiden Surname) Mary Jane Holden				
19e. Informant's Name/Relationship (Type, Print) Carroll W. Myers/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 113 S. College Avenue, Chestertown, Maryland 21620				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chester Cemetery/June 20, 1996		Date June 20, 1996		20c. Location - City or Town, State Chestertown, Maryland		
21. Signature of Funeral Service Licensee Rick J. Helfenbein				22. Name and Address of Facility Fellows, Helfenbein & Newman Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620				
23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <u>Pneumonia Ca</u> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 2/96
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>r/a</u>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <u>Patrick J. Shanahan</u>				29c. License number D36054		29d. Date signed (Month, Day, Year) June 17, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Patrick J. Shanahan, 120 Speer Road, Chestertown, Maryland 21620								
31. Date filed (Month, Day, Year) JUN 19 '96		32. Registrar's Signature <u>John A. Randall</u>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or items 23a or 24a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



## Certificate of Death

Reg. No.

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) <div>Margot Mayher</div>		2. Date of Death Month August Day 13 Year 96 3. Time of Death 7:12 pm							
		4e. Facility Name (If not institution, give street and number) <div>Johns Hopkins Hospital</div>		4b. City, Town, or Location of Death <div>Baltimore</div>							
Funeral Director		5. Social Security Number <div>221-24-4966</div>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. <div>60</div>		8. Date of Birth (Month, Day, Year) <div>Jan 30 1936</div>		9. Birthplace (State or Foreign Country) <div>Delaware</div>	
		10a. State <div>MD</div>		10b. County <div>Anne Arundel</div>		10c. City, Town or Location <div>Edgewater</div>		10d. inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director		10e. Street and Number <div>168 Cardamon Drive</div>		10f. Zip Code <div>21037</div>		10g. Citizen of What Country? <div>United States</div>					
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <div>White</div>			
To Be Completed by Physician/Medical Examiner		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <div>5 plus</div>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <div>Tour Guide</div>		16b. Kind of Business/Industry <div>Touring</div>					
		17. Father's Name (First, Middle, Last) <div>Dr. Godfried Metzler</div>		18. Mother's Name (First, Middle, Maiden Surname) <div>Margaret Fisher</div>							
Physician /Medical Examiner		19a. Informant's Name/Relationship (Type, Print) <div>Robert J. Mayher-Husband</div>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <div>168 Cardamon Drive Edgewater, Maryland 21037</div>							
		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify):		20b. Place of Disposition (Name of cemetery, crematory or other place) <div>Ht. Lincoln Crematory</div>		20c. Location - City or Town, State <div>Brentwood, Maryland</div>					
To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee <div>Donald S. Lytle</div>		22. Name and Address of Facility <div>John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401</div>							
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div>Overwhelming sepsis</div> <div>Endocarditis</div> <div>central line infection</div>		Approximate Interval Between Onset and Death <div>1 week</div> <div>1 week</div> <div>&gt; 1 week</div>							
To Be Completed by Physician/Medical Examiner		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <div>Dilated cardiomyopathy</div> <div>Insulin dependent diabetes mellitus</div>		23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
		24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <div></div>		28b. Time of Injury <div>M</div>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <div></div>	
To Be Completed by Physician/Medical Examiner		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <div>Dr. Campbell, MD; Attending Intensivist</div>		29c. License number <div>D39104</div>		29d. Date signed (Month, Day, Year) <div>August 13, 1996</div>			
		30. Name and address of person who completed cause of death (item 23a) (Type, Print) <div>K. Campbell 600 N. Wolfe St, Halsted 7, Baltimore, MD 21207</div>									
State Registrar		31. Date filed (Month, Day, Year) <div>AUG 15 1996</div>		32. Registrar's Signature <div>Julian Davidson-Randall</div>							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25833

AMENDED # 6,7,8,9  
WCHD 08/19/96 PJS

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROBERT IRVING MEARS</b>				2. Date of Death Month <b>August</b> Day <b>7</b> Year <b>1996</b>		3. Time of Death <b>11:55 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>1240 Middleneck Dr., Apt. H</b>				4b. City, Town, or Location of Death <b>Salisbury</b>		4c. County of Death <b>Wicomico</b>	
Funeral Director	5. Social Security Number <b>115-12-6946</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>87</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>09/30/08</b>	9. Birthplace (State or Foreign Country) <b>VA.</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Salisbury</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>1240 Middleneck Dr., Apt. H</b>				10f. Zip Code <b>21801</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>Army</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Captain</b>		16b. Kind of Business/Industry <b>Boat</b>		
17. Father's Name (First, Middle, Last) <b>Edward J. Mears</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Elizabeth Bishop</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Lynn Clarkson/niece</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Tupelo, Mississippi</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Salisbury Crematory</b>		Data <b>8/8/96</b>		20c. Location - City or Town, State <b>Salisbury, MD</b>
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Coronary Insufficiency</b> Due to (or as a consequence of): <b>b. Atherosclerotic Cardiovascular Disease</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>								Approximate Interval Between Onset and Death <b>Went Sick 7/25/96</b> <b>1995</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		
				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 		29c. License number <b>DD 1969</b>		29d. Date signed (Month, Day, Year) <b>8/8/96</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JAMES H. CLIFFORD MD 106 PINE BLUFF RD LITE 12 SALISBURY MD 21801</b>								
31. Date filed (Month, Day, Year) <b>AUG 08 1996</b>				32. Registrar's Signature 				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





96 25834

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Bernice E. Marshall</b>				2. DATE OF DEATH <b>Aug. 9, 1996</b>		3. TIME OF DEATH <b>5:05 A M</b>	
4. SOCIAL SECURITY NUMBER <b>212-22-1250</b>		5. SEX <b>1 M 2 F</b>		6. AGE (In yrs. last birthday) <b>69</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Oct. 12, 1926</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Edw. W. McCready Memorial Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Crisfield</b>		9c. COUNTY OF DEATH <b>Somerset</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Somerset</b>		10c. CITY, TOWN OR LOCATION <b>Crisfield</b>		10d. INSIDE CITY LIMITS? <b>1 YES 2 NO</b>	
10e. STREET AND NUMBER <b>113 Second St.</b>				10f. ZIP CODE <b>21817</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <b>1 Never Married 2 Married</b> <b>3 Widowed 4 Divorced</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b> IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 NO</b> Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) Grade 7</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>None</b>		15b. KIND OF BUSINESS/INDUSTRY <b>- - -</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Howard Marshall</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Venie Evans</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Erma K. Marshall (sister-in-law)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>113 Second St. - Crisfield, MD 21817</b>			
20a. METHOD OF DISPOSITION <b>1 Burial 2 Cremation 3 Removal from State</b> <b>4 Donation 5 Other (Specify)</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Salisbury Crematory 8/10/96</b>		20c. LOCATION — City or Town, State <b>Salisbury, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Robert H. Bradshaw</b>				22. NAME AND ADDRESS OF FACILITY <b>Bradshaw &amp; sons Funeral Home 306 W. Main St. - Crisfield, MD 21817</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Acute Myocardial Infarction</b>				Approximate Interval Between Onset and Death <b>2 hrs</b>	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <b>SEPSIS</b>				2 days	
		c. <b>Hypertension</b>				YRS	
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <b>1 YES 2 NO</b>				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 YES 2 NO</b>			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 YES 2 NO</b>		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>					
27. MANNER OF DEATH <b>1 Natural 2 Accident 3 Suicide 4 Homicide</b> <b>5 Pending investigation 6 Could not be determined</b>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1 YES 2 NO</b>	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dr. Albert Dacanay</b>				29c. LICENSE NUMBER <b>D29987</b>		29d. DATE SIGNED (Month, Day, Year) <b>August 9/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Albert Dacanay, McCready Hospital, Crisfield, Md. 21817</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 15 1996</b>		32. REGISTRAR'S SIGNATURE <b>John Swisher</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 687600 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 25835

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Irene G. Nicholson</b>				2. Date of Death Month <b>August</b> Day <b>1</b> Year <b>1996</b>		3. Time of Death <b>4:00 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Anne Arundel Medical Center</b>				4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>577-40-5165</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>82</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 21, 1914</b>	
	9. Birthplace (State or Foreign Country) <b>London, England</b>		10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Davidsonville</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>3889 Queen Anne Bridge Road</b>		10f. Zip Code <b>21035</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Clerk</b>		16b. Kind of Business/Industry <b>Safeway Food</b>			
	17. Father's Name (First, Middle, Last) <b>Henry Herbert Hackshaw</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Jessie Radford</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Patricia McNamara / Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3889 Queen Anne Bridge Road Davidsonville, Md. 21035</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lakemont Memorial Gardens</b>		20c. Location - City or Town, State <b>8-5-96 Davidsonville, Maryland</b>			
	21. Signature of Funeral Service Licensee <b>Robert E. Evans Pres</b>		22. Name and Address of Facility <b>Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Maryland 20715</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>COPD</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Due to (or as a consequence of):</b>  <b>Due to (or as a consequence of):</b>  <b>Due to (or as a consequence of):</b>		Approximate Interval Between Onset and Death					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>M</b>		28b. Time of Injury <b>1</b> Yes <input checked="" type="checkbox"/> No		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Wm. L. G. G. G.</b>		29c. License number <b>D24768</b>		29d. Date signed (Month, Day, Year) <b>8/2/96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>600 RIDGELY AVE, ANNAPOLIS</b>		31. Date filed (Month, Day, Year) <b>AUG 09 1996</b>		32. Registrar's Signature <b>John Davidson Randall</b>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25836

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RALPH FRANKLIN NOCK				2. Date of Death Month Day Year July 31, 1996		3. Time of Death 2:43 P.M.		
	4a. Facility Name (If not institution, give street and number) 223 Monticello Ave.				4b. City, Town, or Location of Death Salisbury		4c. County of Death Wicomico		
Funeral Director	5. Social Security Number 218-20-5183	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 19, 1926		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland	10b. County Wicomico	10c. City, Town or Location Salisbury			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 223 Monticello Ave.			10f. Zip Code 21801		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (14 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assembler		16b. Kind of Business/Industry Gasoline Pump Mfg.				
	17. Father's Name (First, Middle, Last) Charles Thomas Nock Sr.				18. Mother's Name (First, Middle, Maiden Surname) Clara Edna Parker				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Claire M. Nock			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 223 Monticello Ave., Salisbury, MD 21801					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment		20b. Place of Disposition (Name of cemetery, crematory or other place) Wicomico Memorial Park		20c. Date 8/3/96		20d. Location - City or Town, State Salisbury, MD		
	21. Signature of Funeral Service Licensee <i>John H. Hefner</i>			22. Name and Address of Facility Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21801					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Myocardial Infarction</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death <i>1 yr</i>								
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier <i>Dr. David Connolly</i>				29c. License number D26278		29d. Date signed (Month, Day, Year) 8-1-96			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Connolly, MD 145 E. Carroll St. Salisbury, MD 21801									
31. Date filed (Month, Day, Year) AUG 02 1996				32. Registrar's Signature <i>John H. Hefner</i>					

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25837

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>SARAH A. ONEAL</i>				2. Date of Death Month <i>July</i> Day <i>31</i> Year <i>1996</i>		3. Time of Death <i>8:20 PM</i>	
	4a. Facility Name (If not institution, give street and number) <i>Washington Adventist Hospital</i>				4b. City, Town, or Location of Death <i>Takoma Park</i>		4c. County of Death <i>Montgomery</i>	
Funeral Director	5. Social Security Number <i>250-11-7051</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>94</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>June 4, 1902</i>	9. Birthplace (State or Foreign Country) <i>South Carolina</i>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <i>Maryland</i>		10b. County <i>Prince Georges</i>		10c. City, Town or Location <i>Adelphi</i>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <i>1801 Metzert Road</i>				10f. Zip Code <i>20783</i>		10g. Citizen of What Country? <i>United States</i>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>	
	15. Decedent's Education (Specify only highest grade completed) <i>8th grade</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Housewife</i>		16b. Kind of Business/Industry <i>Domestic</i>	
	17. Father's Name (First, Middle, Last) <i>unknown</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Estelle Smith</i>			
	19a. Informant's Name/Relationship (Type, Print) <i>Dorothy G. Morton (daughter)</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>9404 Dogwood Place, Capitol Heights, Maryland 20743</i>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Ebenezer Baptist Church Cemetery</i>		20c. Date <i>Aug. 5, 1996</i>		20d. Location - City or Town, State <i>Barnwell County, Williston, South Carolina</i>	
	21. Signature of Funeral Service Licensee <i>Bernice L. Jones III</i>				22. Name and Address of Facility <i>Latney's Funeral Home, Inc. 3831 Georgia Avenue, N.W.; Washington, D.C. 20011</i>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>a. Congestive Heart Failure</i> Due to (or as a consequence of): <i>b. Acute Renal Failure</i> Due to (or as a consequence of): <i>c. Urinary Tract Infection</i> Due to (or as a consequence of): <i>d. Hypertension. Anemia.</i>							
	Approximate Interval Between Onset and Death <i>24 hr.</i> <i>24 hr.</i> <i>14 days</i> <i>&gt; 7 years.</i>							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Myocardial infarction</i>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred						28e. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <i>D19609</i>		29d. Date signed (Month, Day, Year) <i>8-1-96</i>	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>Raman Tuli, M.D.; 10810 Dainestown Road, Gaithersburg, Maryland 20878</i>							
	State Registrar	31. Date filed (Month, Day, Year) <i>AUG 07 1996</i>				32. Registrar's Signature <i>John D. ...</i>		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

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State of Maryland / Department of Health and Mental Hygiene

96 25838

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>EVELYN ALICE OUTTEN</b>				2. Date of Death Month <b>08</b> Day <b>09</b> Year <b>96</b>		3. Time of Death <b>1050</b>	
	4a. Facility Name (If not institution, give street and number) <b>103 MONUMENT SQUARE</b>				4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>	
Funeral Director	5. Social Security Number <b>083-12-8680</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>73</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>11-08-22</b>	
	9. Birthplace (State or Foreign Country) <b>New York</b>		10a. State <b>Maryland</b>		10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Salisbury</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <b>103 Monument Square</b>		10f. Zip Code <b>21804</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Salesperson</b>		16b. Kind of Business/Industry <b>Furniture</b>			
	17. Father's Name (First, Middle, Last) <b>Carl Henry Still</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ethel Rose Patton</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Gary Outten/son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>30317 Aylmore Ave., Salisbury, MD 21801</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Springhill Memory Gardens</b>		20c. Location - City or Town, State <b>Hebron, MD</b>		20d. Date <b>8/13/96</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Holloway Funeral Home</b> <b>501 Snow Hill Rd., Salisbury, MD 21804</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. _____</b> Due to (or as a consequence of): <b>c. _____</b> Due to (or as a consequence of): <b>d. _____</b>							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CAROTID STENOSIS, HYPERTENSION</b>							
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier  <b>D.M.E.</b>				29c. License number <b>D03599</b>		29d. Date signed (Month, Day, Year) <b>08-09-96</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>JOHN T. BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY, MD 21801</b>								
31. Date filed (Month, Day, Year) <b>AUG 13 1996</b>				32. Registrar's Signature 				

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25839

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

OMAR BERTON OWENS JR.

2. Date of Death

Month August 3, Day 1996 Year

3. Time of Death

8:45 P.M.

4a. Facility Name (If not institution, give street and number)

7014 Cherry Walk Rd.

4b. City, Town, or Location of Death

Hebron

4c. County of Death

Maryland

5. Social Security Number

213-24-4996

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
October 6, 1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Hebron

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7014 Cherry Walk Rd.

10f. Zip Code

21830

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Shipper

16b. Kind of Business/Industry

Dresser Industries

17. Father's Name (First, Middle, Last)

Omar Berton Owens Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Eva Virginia Messick

19a. Informant's Name/Relationship (Type, Print)

Frances Ann Owens/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7014 Cherry Walk Rd., Hebron, MD 21830

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Springhill Memory Gardens

Date

8/7/96

20c. Location - City or Town, State

Hebron, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Holloway Funeral Home

501 Snow Hill Rd., Salisbury, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. *Cancer of the lung with Metastasis* 2 yrs.  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Chronic Obstructive Lung Disease*

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D-20050

29d. Date signed (Month, Day, Year)

8/6/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BENITO S. CHAN 547-D Riverside Dr. Solby, MD 21801

31. Date filed (Month, Day, Year)

AUG 08 1996

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the report is a general introduction to the subject of the study.

2. The second part of the report is a detailed description of the methods used in the study.

3. The third part of the report is a discussion of the results of the study.

4. The fourth part of the report is a conclusion and a list of references.

5. The fifth part of the report is a list of appendices.

6. The sixth part of the report is a list of figures and tables.

7. The seventh part of the report is a list of abbreviations and symbols.

8. The eighth part of the report is a list of acknowledgments.

9. The ninth part of the report is a list of footnotes.

10. The tenth part of the report is a list of references.

11. The eleventh part of the report is a list of appendices.

12. The twelfth part of the report is a list of figures and tables.

13. The thirteenth part of the report is a list of abbreviations and symbols.

14. The fourteenth part of the report is a list of acknowledgments.

15. The fifteenth part of the report is a list of footnotes.

16. The sixteenth part of the report is a list of references.

17. The seventeenth part of the report is a list of appendices.

18. The eighteenth part of the report is a list of figures and tables.

19. The nineteenth part of the report is a list of abbreviations and symbols.

20. The twentieth part of the report is a list of acknowledgments.

21. The twenty-first part of the report is a list of footnotes.

22. The twenty-second part of the report is a list of references.

23. The twenty-third part of the report is a list of appendices.

24. The twenty-fourth part of the report is a list of figures and tables.

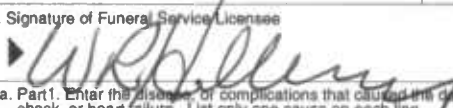

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25840

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HERBERT FREDERICK OLSEN</b>						2. Date of Death Month <b>Aug.</b> Day <b>7</b> Year <b>1996</b>		3. Time of Death <b>12:25 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Salisbury Center; Genesis ElderCare</b>						4b. City, Town, or Location of Death <b>Salisbury, Md.</b>		4c. County of Death <b>Wicomico</b>	
Funeral Director	5. Social Security Number <b>133-18-4343</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>69</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 7, 1927</b>		9. Birthplace (State or Foreign Country) <b>New York</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Salisbury</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>503 Viewfield Drive</b>				10f. Zip Code <b>21801</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>Army</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>5</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Chief Financier</b>			16b. Kind of Business/Industry <b>Radio Broadcasting</b>		
	17. Father's Name (First, Middle, Last) <b>Anton Frederick Olsen</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Mabel Florence Bernhard</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Audrey J. Olsen/spouse</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>503 Viewfield Drive, Salisbury, MD 21801</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Anatomy Board</b>		Date <b>8/7/96</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Multiple Sclerosis</b> Due to (or as a consequence of): <b>Pneumonia</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Multiple Sclerosis</b> Due to (or as a consequence of): <b>Pneumonia</b> <b>Multiple Sclerosis</b> Due to (or as a consequence of): <b>Pneumonia</b>									
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
State Registrar	29b. Signature and title of certifier 				29c. License number <b>D-29349</b>		29d. Date signed (Month, Day, Year) <b>8/8/96</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. WILLIAM ROBINS, 1104 HEALTHWAY DR., SALISBURY, MD. 21804</b>									
31. Date filed (Month, Day, Year) <b>AUG 08 1996</b>										
32. Registrar's Signature 										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

96 25841

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LOUISE I. POWELL</b>				2. Date of Death Month <b>JULY</b> Day <b>26</b> Year <b>1996</b>				3. Time of Death <b>7:05pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>WASHINGTON ADVENTIST HOSPITAL</b>				4b. City, Town, or Location of Death <b>TAKOMA PARK</b>				4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>218-64-6119</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>74</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>November 28, 1921</b>		9. Birthplace (State or Foreign Country) <b>Jamaica</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Prince Georges</b>		10c. City, Town or Location <b>Hyattsville</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>2251 Lewisdale Drive</b>				10f. Zip Code <b>20783</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nursing Assistant</b>			16b. Kind of Business/Industry <b>Private</b>		
	17. Father's Name (First, Middle, Last) <b>Stephen Dwyer</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Agnes Powell</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Rose Dennis</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2251 Lewisdale Drive Hyattsville Md. 20783</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery</b>		20c. Date <b>8/1/96</b>		20d. Location - City or Town, State <b>Silver Spring, Md.</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Johnson &amp; Jenkins Inc. 716 Kennedy St., N.W. Wash. D.C. 20011</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>CARDIOPULMONARY ARREST</b> Due to (or as a consequence of): b. <b>DIABETES MELLITUS</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 				29c. License number <b>D45796</b>		29d. Date signed (Month, Day, Year) <b>8/6/96</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Clayton Straughn, MD. 6525 Belcrest Road, Hyattsville, Md. 20782</b>										
31. Date filed (Month, Day, Year) <b>AUG 07 1996</b>		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 25842

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROSE LEE PROPHET</b>				2. Date of Death Month Day Year <b>AUGUST 2, 1996</b>		3. Time of Death <b>10:00AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>11508 MARY CATHERINE COURT</b>				4b. City, Town, or Location of Death <b>CLINTON</b>		4c. County of Death <b>PRINCE GEORGE'S</b>	
Funeral Director	5. Social Security Number <b>260-38-3539</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>71 Yrs.</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>DEC. 17, 1924</b>	9. Birthplace (State or Foreign Country) <b>GEORGIA</b>
	Usual Residence of Decedent							
10a. State <b>MARYLAND</b>		10b. County <b>PRINCE GEORGE'S</b>		10c. City, Town or Location <b>CLINTON</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>11508 MARY CATHERINE COURT</b>				10f. Zip Code <b>20735</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>2 YEARS</b>				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SALES MANAGER</b>			18b. Kind of Business/Industry <b>HIGH'S DAIRY(PVT.)</b>	
17. Father's Name (First, Middle, Last) <b>ROBERT PERKINS</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>MATTIE WILLIS</b>				
19a. Informant's Name/Relationship (Type, Print) <b>JOYCE GRIGGS/ DAUGHTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11508 MARY CATHERINE COURT CLINTON, MD 20735</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HARMONY MEMORIAL PARK</b>		Data <b>8-8-96</b>		20c. Location - City or Town, State <b>LANDOVER, MARYLAND</b>		
21. Signature of Funeral Service Licensee <i>Shawana Braxton</i>				22. Name and Address of Facility <b>MARSHALL'S FUNERAL HOME OF MD 4308 SUITLAND RD. SUITLAND, MARYLAND 20746</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. MALIGNANT LYMPHOMA</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>18 mos</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Sept Steel MD</i>		29c. License number <b>D18912</b>		29d. Date signed (Month, Day, Year) <b>8/6/96</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>8300 CORPORATE DR CLANDOVER MD 20785</b>								
31. Date filed (Month, Day, Year) <b>AUG 06 1996</b>		32. Registrar's Signature <i>John Andrew Raskell</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a discussion of the experimental design, the data collection procedures, and the statistical analysis techniques.

3. The third part of the report is a presentation of the results of the study. It includes a discussion of the findings, the interpretation of the results, and the conclusions drawn from the study.

4. The fourth part of the report is a discussion of the implications of the study. It includes a discussion of the limitations of the study, the strengths of the study, and the suggestions for further research.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 25843

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lillian M Putnam</b>				2. Date of Death Month <b>Aug</b> Day <b>15</b> Year <b>1996</b>		3. Time of Death <b>5:05 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Waldorf Healthcare Center</b>				4b. City, Town, or Location of Death <b>Waldorf</b>		4c. County of Death <b>Charles</b>	
Funeral Director	5. Social Security Number <b>226-24-3456</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>76</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 1, 1920</b>	9. Birthplace (State or Foreign Country) <b>Virginia</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10e. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Clinton</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>5404 Pizarro Court</b>				10f. Zip Code <b>20735</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Accounting</b>			16b. Kind of Business/Industry <b>Government</b>	
	17. Father's Name (First, Middle, Last) <b>Wilbur Hughes</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Clarke</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Linda C. Nitz</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5404 Pizarro Court, Clinton, Maryland 20735</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Fort Lincoln Cemetery</b>		20c. Location - City or Town, State <b>Brentwood, Maryland</b>		20d. Date <b>Aug 17, 1996</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. CARDIOMYOPATHY, END STAGE 'FEW YRS</b> Due to (or as a consequence of): <b>b. CORONARY ARTERY DISEASE YRS</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Approximate Interval Between Onset and Death							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>METASTASIS - BRAIN/LIVER</b> <b>MALNUTRITION</b> <b>ATRIAL FIBRILLATION</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Attending		29c. License number <b>D-44436</b>		29d. Date signed (Month, Day, Year) <b>August 15 1996</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. A. Patel 603 Post Office Road, #207, Waldorf, Maryland</b>							
	31. Date filed (Month, Day, Year) <b>AUG 20 1996</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



96 25844

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Sylvia Mae Parson</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Aug. 12 1996</b>		3. TIME OF DEATH <b>9:45 P.</b>	
4. SOCIAL SECURITY NUMBER <b>214-34-5663</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>59</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Feb. 14 1937</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>27002 South Tourmaline Drive</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Hebron</b>	
9c. COUNTY OF DEATH <b>Wicomico</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Wicomico</b>	
10c. CITY, TOWN OR LOCATION <b>Hebron</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>27002 South Tourmaline Drive</b>	
10f. ZIP CODE <b>21830</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Social Worker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>None</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Samuel Winder</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Blanche Price</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Donald Parson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>27002 South Tourmaline DR. Hebron, Md. 21830</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Springhill Mem. Gardens 8/16</b>		20c. LOCATION — City or Town, State <b>Hebron, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Bladys B. Stewart</b>				22. NAME AND ADDRESS OF FACILITY <b>Stewart Funeral Home 821 West Rd. Salisbury, Md. 21801</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>metastatic leiomyosarcoma</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Joseph A. Grasso MD</b>				29c. LICENSE NUMBER <b>D20507</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/14/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Joseph A. Grasso 145 E. CARROLL ST Salisbury MD 21801</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 14 1996</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25845

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joseph Coleman Payne, Jr.				2. Date of Death Month Day Year August 15, 1996				3. Time of Death 23:55			
	4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital				4b. City, Town, or Location of Death Prince Frederick				4c. County of Death Calvert			
Funeral Director	5. Social Security Number 227 74 7006		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 45 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.			
	8. Date of Birth (Month, Day, Year) Sept. 12, 1950		9. Birthplace (State or Foreign Country) Wash., DC									
To Be Completed by Funeral Director	Usual Residence of Decedent											
	10a. State MD		10b. County Calvert		10c. City, Town or Location North Beach				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 8834 Chesapeake Lighthouse Dr.				10f. Zip Code 20714				10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1974-89		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: white			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4or 5+) 2				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Military Serviceman				16b. Kind of Business/Industry US Army			
	17. Father's Name (First, Middle, Last) Joseph Coleman Payne, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Thelma Cash							
	19a. Informant's Name/Relationship (Type, Print) Theresa Arnaud/friend				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as 10 above							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) MD Veterans Cemetery		Date 8-19-96		20c. Location - City or Town, State Cheltenham, MD			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Rausch Funeral Home, Owings, MD 20736							
	Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <u>Respiratory failure</u> Due to (or as a consequence of): b. <u>pneumonia</u> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____										Approximate Interval Between Onset and Death 4 weeks 2 weeks
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 				29c. License number D46246		29d. Date signed (Month, Day, Year) August 16, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. A. MEELU, WALDORF, MD 20603												
State Registrar		31. Date filed (Month, Day, Year) AUG 19 1996				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10 x 1 1/4





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25846

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Helen K

2. Date of Death

Month Day Year  
Aug. 7 1996

3. Time of Death

1:24 p.m.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

6404 Halleck Street

4b. City, Town, or Location of Death

Dist. Hgts, MD

4c. County of Death

Prince George

5. Social Security Number

578-10-9804

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 29, 1910

9. Birthplace (State or Foreign Country)

Budapest, Hungary

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

District Heights

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6404 Halleck Street

10f. Zip Code

20747

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

18a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

18b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Frank Joseph Kopany

18. Mother's Name (First, Middle, Maiden Surname)

Maria Kascsak

19a. Informant's Name/Relationship (Type, Print)

Margaret Tracey

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

900 McKinley Road, Arlington, Virginia 22205

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

Aug. 5, 96

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

Lisa S. Johnson

22. Name and Address of Facility

Fort Lincoln Funeral Home, Inc.  
3401 Bladensburg Road, Brentwood, Maryland 2072223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Acute Coronary Thrombosis

minutes

Due to (or as a consequence of):

b. Arteriosclerosis

10 yrs (+)

Due to (or as a consequence of):

c. Diabetes mellitus

10 yrs (+)

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

Residence

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Walter B. Sheer MD.

29c. License number

D 10272 MD Aug. 5, 1996

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Walter B. SHEER MD. - 6400 MARLBORO PIKE - DIST. HGTS, MD 20747

31. Date filed (Month, Day, Year)

AUG 07 1996

32. Registrar's Signature

John Andrew Randall

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25847

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LILLIAN P. ROBINSON</b>				2. Date of Death Month Day Year <b>Aug. 2, 1996</b>			3. Time of Death <b>1:00 P.M.</b>			
	4a. Facility Name (If not institution, give street and number) <b>Southern Maryland Hospital</b>				4b. City, Town, or Location of Death <b>Clinton</b>			4c. County of Death <b>Prince George's</b>			
Funeral Director	5. Social Security Number <b>578-20-4675</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>90</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug. 7, 1905</b>		9. Birthplace (State or Foreign Country) <b>South Hampton City, VA</b>		
	Usual Residence of Decedent				10c. City, Town or Location <b>Clinton</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
To Be Completed by Funeral Director	10e. State <b>Maryland</b>		10f. Zip Code <b>20735</b>		10g. Citizen of What Country? <b>United States</b>						
	11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Retired Seamstress</b>		16b. Kind of Business/Industry <b>Private</b>						
	17. Father's Name (First, Middle, Last) <b>Charlie Person</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sallie Wyche</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>Charles C. Robinson - Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4501 Stecoah Drive, Clinton, Maryland 20735</b>						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lincoln Memorial Cemetery</b>		20c. Location - City or Town, State <b>Suitland, Maryland</b>						
	21. Signature of Funeral Service Licensee <b>John T. Stewart III</b>				22. Name and Address of Facility <b>STEWART FUNERAL HOME, Inc.</b> <b>4001 Benning Road, N.E., Washington, D. C.</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Acute Myocardial Infarction 1 day</b>				Approximate Interval Between Onset and Death <b>1 day</b>						
	23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Coronary Artery Disease YRS.</b>										
	23c. Part III. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Respiratory Failure</b>										
23d. Part IV. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Congestive Heart Failure</b>											
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			
28a. Date of Injury (Month, Day, Year)				28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>Dr. [Signature] Attending</b>				29c. License number <b>D-44436</b>		29d. Date signed (Month, Day, Year) <b>Aug 02 '96</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ASHVINKUMAR J PATEL MD 603 Post OFFICERS WALDORF MD 20602</b>				31. Date filed (Month, Day, Year) <b>AUG 06 1996</b>				32. Registrar's Signature <b>[Signature]</b>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State  
Registrar



96 25848

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Paul F. Richards				2. DATE OF DEATH August 18 1996		3. TIME OF DEATH 6:00 A.M.	
4. SOCIAL SECURITY NUMBER 216-44-3622		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 02-22-10	
8. BIRTHPLACE (State or Foreign Country) New York				9a. FACILITY NAME (If not institution, give street and number) 6881 Hungerford Rd.		9b. CITY, TOWN OR LOCATION OF DEATH Bryans Road	
9c. COUNTY OF DEATH Charles				10a. STATE Maryland		10b. COUNTY Charles	
10c. CITY, TOWN OR LOCATION Indian Head				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 8 Pine Street	
10f. ZIP CODE 20640				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Foreman		16b. KIND OF BUSINESS/INDUSTRY Federal Government	
17. FATHER'S NAME (First, Middle, Last) Eugene Richards				18. MOTHER'S NAME (First, Middle, Maiden Surname) Emma Richards			
19a. INFORMANT'S NAME (Type/Print) Donald Richards				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5501 Fisher Dr. Temple Hills, MD 20748			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Trinity Memorial Gardens 8/19 Waldorf, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE M00817 Gautier C. Echols III				22. NAME AND ADDRESS OF FACILITY Arehart-Echols Funeral Home, Inc. P.O. Box 567 La Plata, MD 20646			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sudden death DUE TO (OR AS A CONSEQUENCE OF):							
b. Acute myocardial infarction DUE TO (OR AS A CONSEQUENCE OF):							
c. Coronary artery disease DUE TO (OR AS A CONSEQUENCE OF): 12yr.							
d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Basal cell carcinoma right orbital space							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER A.O. Wooddy MD				29c. LICENSE NUMBER Md 011176		29d. DATE SIGNED (Month, Day, Year) 08-16-96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A.O. Wooddy MD 100 Washington Ave, La Plata, Md. 20646							
31. DATE FILED (Month, Day, Year) AUG 19 1996				32. REGISTRAR'S SIGNATURE John Shivers-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25849

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN Reilly

2. Date of Death

JULY 28, 1996

3. Time of Death

500PM

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

096 16 4303

6. Sex

M ☒ F ☐

7. Age (in yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 27, 1921

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Minnesota

10b. County

Dakota

10c. City, Town or Location

Burnsville

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

14701 Portland Ave.

10f. Zip Code

55306

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sales

16b. Kind of Business/Industry

NCR

17. Father's Name (First, Middle, Last)

John J. Reilly

18. Mother's Name (First, Middle, Maiden Surname)

Marion Jensen

19a. Informant's Name/Relationship (Type, Print)

John A. Reilly Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14701 Portland Ave. Burnsville Minnesota 55306

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 7/30/96

Date

20c. Location - City or Town, State

Alexandria Virginia

21. Signature of Funeral Service Licensee

Robert E. Evans Pres

22. Name and Address of Facility

Robert E. Evans Funeral Home, P.A.  
16000 Annapolis Rd. Bowie Md. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPTIC SHOCK

Due to (or as a consequence of):

b. MULTIFACET DEMENTIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. CHRONIC OBSTRUCTIVE PULMONARY DISEASE 5 YEARS

Due to (or as a consequence of):

d. SEIZURE DISORDER

Approximate Interval Between Onset and Death

1 DAY

2 YEARS

5 YEARS

5 YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dan H. Schreiber MD

29c. License number

D28221

29d. Date signed (Month, Day, Year)

July 28, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAN H. SCHREIBER MD 301 HOSPITAL DRIVE GLEN BURNIE MARYLAND

31. Date filed (Month, Day, Year)

AUG 09 1996

32. Registrar's Signature

Julia Davidson-Randall

21061

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25850

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EMILIE S. ROBERTSON

2. Date of Death

Month  
8Day  
1Year  
96

3. Time of Death

3:40 PM

4a. Facility Name (If not institution, give street and number)

7514 NEWBERRY LA

4b. City, Town, or Location of Death

LANHAM

4c. County of Death

PRINCE GEORGES CO.

Funeral  
Director

5. Social Security Number

188-12-8508

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year

9-22-23

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland Prince Georges

10b. County

10c. City, Town or Location

Lanham

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7514 Newberry Lane

10f. Zip Code

20706

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Registered Nurse

16b. Kind of Business/Industry

Health Care

17. Father's Name (First, Middle, Last)

Wade H. Swingle

18. Mother's Name (First, Middle, Maiden Surname)

Candace M. Davis

19a. Informant's Name/Relationship (Type, Print)

Louise Haas/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7514 Newberry Lane Lanham, Maryland 20706

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

20c. Location - City or Town, State

Lakemont Memorial Gardens 8-5-96 Davidsonville, Maryland

21. Signature of Funeral Service Licensee

Robert E. Evans, Pres.

22. Name and Address of Facility

Robert E. Evans Funeral Home, P.A.

16000 Annapolis Road Bowie, Maryland 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Ascites and intra-abdominal malignancy

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Biliary carcinoma

Due to (or as a consequence of):

years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James W. Harding MD

29c. License number

DO 5401

29d. Date signed (Month, Day, Year)

August 2nd, 1996

30. Name and address of person who completed cause of death (Form 23e) (Type, Print)

James W. Harding M.D. 7525 Greenway Center Greenbelt Md.

31. Date filed (Month, Day, Year)

AUG 09 1996

32. Registrar's Signature

John Anderson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

25



96-4307-033

AM ITEMS: 23 PART I, II, 27, PER

ME0 FTL M 6-738 8/30/96 t.t.  
Amended # 10a. P.G.C. 8-9-96 CR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25851

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

LINDA KAY ROSE

2. Date of Death

Month Day Year  
JULY 31, 1996

3. Time of Death

9:58 a.m.

4a. Facility Name (If not institution, give street and number)

2303 ROSLYN AVE

4b. City, Town, or Location of Death

DISTRICT HEIGHTS

4c. County of Death

PRINCE GEORGES

5. Social Security Number

579-94-5887

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

52 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs

Hours Min.

8. Date of Birth

(Month, Day, Year)

AUGUST 15, 1943

9. Birthplace (State or Foreign Country)

WASHINGTON D.C.

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

PRINCE GEORGE'S

10c. City, Town or Location

DISTRICT HEIGHTS

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2303 ROSLYN AVENUE

10f. Zip Code

20747

10g. Citizen of What Country?

U.S.A

11. Marital Status

X ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

SPECIAL ED

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

NEVER EMPLOYED

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

HARRY W. ROSE, SR.

18. Mother's Name (First, Middle, Maiden Surname)

MARY BARNES

19a. Informant's Name/Relationship (Type, Print)

PAT PIERCE / SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14705 SHILOH CT. #201 LAUREL, MD 20708

20a. Method of Disposition

X ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

CEDAR HILL CEMETERY

Date

8/6/96

20c. Location - City or Town, State

SUITLAND, MD

21. Signature of Funeral Service Licensee

Humbert C. Bluscar-Tome

22. Name and Address of Facility

MARSHALL'S FUNERAL HOME  
4308 SUITLAND RD SUITLAND, MD 2074623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. RUPTURE OF SINUS OF VALSALVA ANEURYSM

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

{

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEIZURE DISORDER; DOWN'S SYNDROME

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

X ☐ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

J. A. Row Locke, MD

29c. License number

OCME

29d. Date signed (Month, Day, Year)

AUGUST 01, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

J. A. Row Locke, MD 111 Penn Street, Baltimore, Maryland 21201

State  
Registrar

31. Date filed (Month, Day, Year)

AUG 09 1996

32. Registrar's Signature

John H. Row Locke

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



1 FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CLAUDIA RICE</b>				2. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 1, 1996</b>		3. TIME OF DEATH <b>1:25 a m</b>	
4. SOCIAL SECURITY NUMBER <b>248-64-3441</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>58</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>OCT. 27, 1937</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>HOLY CROSS HOSPITAL</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>SILVER SPRING</b>		8c. COUNTY OF DEATH <b>MONTGOMERY</b>	
10a. STATE <b>--</b>		10b. COUNTY <b>--</b>		10c. CITY, TOWN OR LOCATION <b>WASHINGTON, D.C.</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>4805 7th ST., N.E.</b>				10f. ZIP CODE <b>20017</b>		10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Collega (1-4 or 5+)</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>DISPATCHER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>GOVERNMENT</b>			
17. FATHER'S NAME (First, Middle, Last) <b>MURRAY PRESSLEY</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>CEILA CUNNINGHAM</b>			
19a. INFORMANT'S NAME (Type/Print) <b>LEROIY RICE</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4805 7th ST., NE WASH., DC 20017</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>FT. LINCOLN CEM. 8-5-96</b>		20c. LOCATION — City or Town, State <b>BRENTWOOD, MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sharon Johnson-Salley</i>				22. NAME AND ADDRESS OF FACILITY <b>CAPITOL MORTUARY 1425 MARYLAND AVE., NE WASH., DC</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death	
a. <i>Necrotizing fasciitis</i> DUE TO (OR AS A CONSEQUENCE OF):						5 weeks	
b. <i>Adult respiratory distress syndrome</i> DUE TO (OR AS A CONSEQUENCE OF):						4 weeks	
c. <i>Sepsis</i> DUE TO (OR AS A CONSEQUENCE OF):						4 weeks	
d. <i>Renal failure</i>						4 weeks	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes</i>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> M.D.				29c. LICENSE NUMBER <b>D 50106</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/2/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>TACKSON TAM, MD 1500 FOREST GLEN RD, SILVER SPRING MD 20901</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 06 1996</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 687600 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25853

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

LOUIS FLOYD RICE

2. Date of Death

Month  
07Day  
26Year  
96

3. Time of Death

1205

4a. Facility Name (If not institution, give street and number)

221 GLEN AVENUE

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

222-03-4577

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

04-05-19

9. Birthplace (State or Foreign Country)

Beaufort, NC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

221 Glen Avenue

10f. Zip Code

21801

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Refrigeration/A.C. Mechanic

16b. Kind of Business/Industry

Civil Service

17. Father's Name (First, Middle, Last)

Harvey Rice

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Ann Avery

19a. Informant's Name/Relationship (Type, Print)

Elizabeth R. Hamilton/Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

221 Glen Avenue, Salisbury, MD 21801

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bethel Methodist Cemetery 1996

Date

07/29

20c. Location - City or Town, State

Lewes, Delaware

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Parsell Atkins & Lodge Funeral Home  
1449 Kings Highway, Lewes, DE 19958

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

YEARS

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE; CARDIAC PACEMAKER, 1994

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

 D.M.E.

29c. License number

D03599

29d. Date signed (Month, Day, Year)

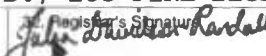
07-26-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN T. BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY, MD, 21801

31. Date filed (Month, Day, Year)

AUG 02 1996

32. Registrar's Signature  
State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25854

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Calvin E

2. Date of Death

Month Day Year

Ross

August 12, 1996

3. Time of Death

1830

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number

222-07-8397

6. Sex

X ☐ M ☐ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug. 4, 1921

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

Wicomico

10c. City, Town or Location

Delmar

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

605 Elizabeth St.

10f. Zip Code

21875

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give

Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Welder

16b. Kind of Business/Industry

Steel Co.

17. Father's Name (First, Middle, Last)

Eugene Ross, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Anna (Maiden unknown)

19a. Informant's Name/Relationship (Type, Print)

Marie E. Ross

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

605 Elizabeth St. Delmar, Md. 21875

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

St. Stephens Cemetery

Date

8-15

20c. Location - City or Town, State

Delmar, De.

21. Signature of Funeral Service Licensee

William M. Short

22. Name and Address of Facility

Short Funeral Home, Inc.

13 E. Grove St. Delmar, De. 19940

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Septic Shock

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

12 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

End Stage Renal Failure

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

8/12/96

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Steven E. Hearne, MD

29c. License number

D40715

29d. Date signed (Month, Day, Year)

8/14/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Steven E. Hearne, MD

403 Quing St. Salisbury, Md. 21801

31. Date filed (Month, Day, Year)

AUG 15 1996

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

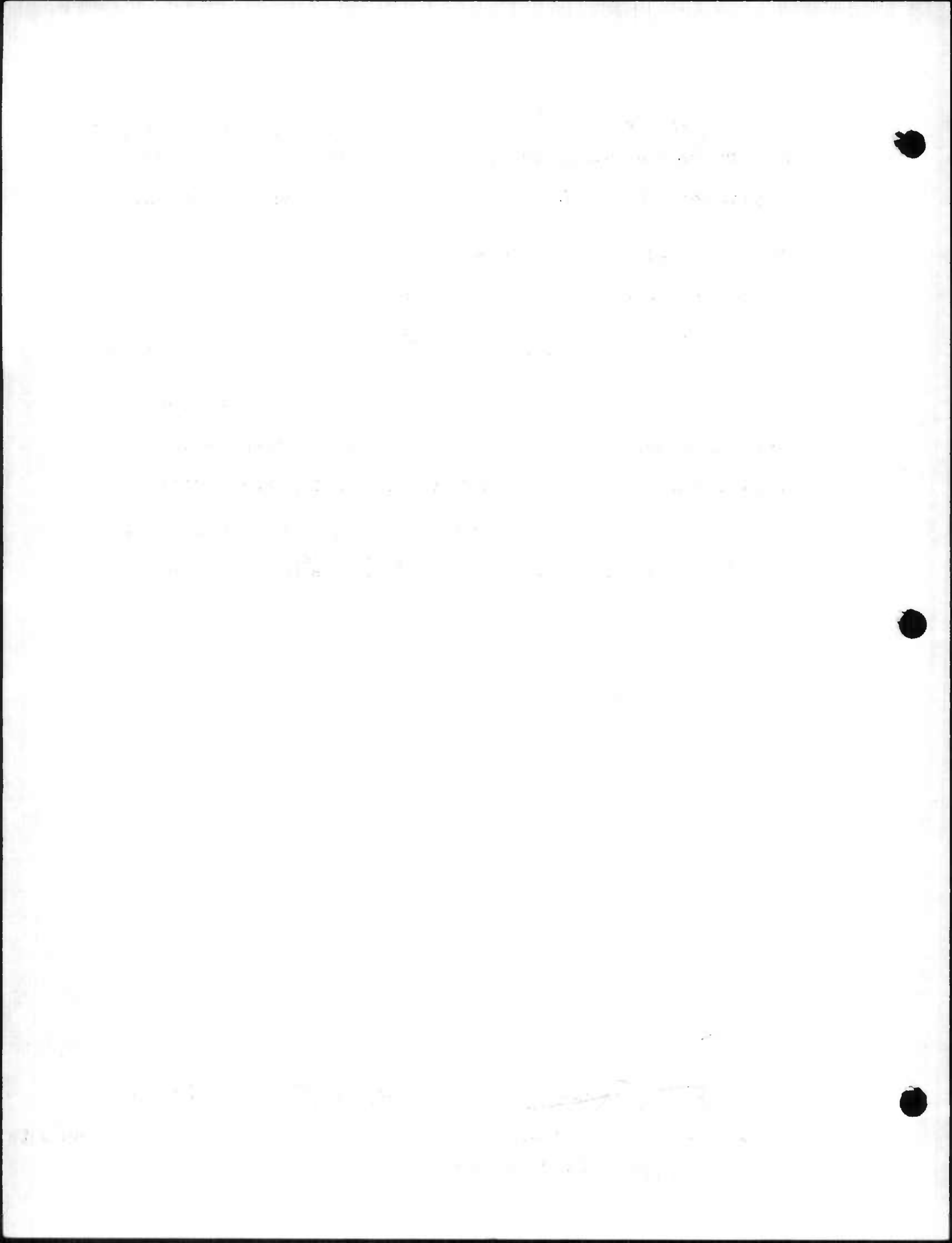
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25855

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Taylor Herbert Renshaw</i>				2. Date of Death Month <i>8</i> Day <i>12</i> Year <i>96</i>		3. Time of Death <i>1:15 AM</i>										
	4a. Facility Name (If not institution, give street and number) <i>822 Riverside Drive</i>				4b. City, Town, or Location of Death <i>Salisbury</i>		4c. County of Death <i>Wicomico</i>										
Funeral Director	5. Social Security Number <i>218-09-3194</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>77</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>October 20, 1918</i>										
	9. Birthplace (State or Foreign Country) <i>Maryland</i>		10a. State <i>Maryland</i>		10b. County <i>Wicomico</i>		10c. City, Town or Location <i>Salisbury</i>										
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No												
	10e. Street and Number <i>822 Riverside Drive</i>				10f. Zip Code <i>21801</i>		10g. Citizen of What Country? <i>USA</i>										
	11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>										
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Banker</i>		16b. Kind of Business/Industry <i>Banking</i>												
	17. Father's Name (First, Middle, Last) <i>Robert Henry Renshaw Jr.</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Henrietta Buchanan Albert</i>												
	19a. Informant's Name/Relationship (Type, Print) <i>Rosalie H. Renshaw/spouse</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>822 Riverside Dr., Salisbury, MD 21801</i>												
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Salisbury Crematory</i>		20c. Location - City or Town, State <i>Salisbury, MD</i>												
	21. Signature of Funeral Service Licensee <i>David Thompson</i> <i>MO1051</i>				22. Name and Address of Facility <i>Holloway Funeral Home</i> <i>501 Snow Hill Rd., Salisbury, MD 21804</i>												
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																
	<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><i>Ca of prostate - metastases to liver</i></td> <td rowspan="4">Approximate Interval Between Onset and Death <i>out at</i></td> </tr> <tr> <td>b.</td> <td><i>lung &amp; bone</i></td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<i>Ca of prostate - metastases to liver</i>	Approximate Interval Between Onset and Death <i>out at</i>	b.	<i>lung &amp; bone</i>	c.		d.
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<i>Ca of prostate - metastases to liver</i>	Approximate Interval Between Onset and Death <i>out at</i>														
	b.	<i>lung &amp; bone</i>															
	c.																
	d.																
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																	
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																	
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined																	
28a. Date of Injury (Month, Day, Year)																	
28b. Time of Injury <i>M</i>																	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																	
28d. Describe how injury occurred																	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)																	
28f. Location (Street and Number or Rural Route Number, City or Town, State)																	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																	
29b. Signature and title of certifier <i>MB Horner MD</i>																	
29c. License number <i>D13053</i>																	
29d. Date signed (Month, Day, Year) <i>8/12/96</i>																	
30. Name and address of person who completed cause of death (item 23a) (Type, Print) <i>William Horner 100 Power St., Salisbury, MD 21804</i>																	
31. Date filed (Month, Day, Year) <i>AUG 13 1996</i>																	
32. Registrar's Signature <i>John Davidson-Randall</i>																	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25856

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Wilmer Albert Ray</b>				2. Date of Death Month <b>June</b> Day <b>18</b> Year <b>1996</b>				3. Time of Death <b>0830 hrs</b>	
	4a. Facility Name (If not institution, give street and number) <b>155 Knights Cornor Road ( AT HOME )</b>				4b. City, Town, or Location of Death <b>Elkton</b>				4c. County of Death <b>Cecil</b>	
Funeral Director	5. Social Security Number <b>222-12-3130</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>69</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>December 5, 1926</b>		9. Birthplace (State or Foreign Country) <b>Delaware</b>	
	Usual Residence of Decedent				10a. State <b>Maryland</b>		10b. County <b>Cecil</b>		10c. City, Town or Location <b>Elkton</b>	
To Be Completed by Funeral Director	10a. State <b>Maryland</b>				10b. County <b>Cecil</b>				10c. City, Town or Location <b>Elkton</b>	
	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <b>155 Knights Cornor Road</b>				10f. Zip Code <b>21921</b>	
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+) <b>College</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Groomsman</b>	
To Be Completed by Physician/Medical Examiner	16b. Kind of Business/Industry <b>Animal Care</b>				17. Father's Name (First, Middle, Last) <b>Andrew Ray Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Blackston</b>	
	19a. Informant's Name/Relationship (Type, Print) <b>Mrs Margaret E. Ray</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>155 Knights Cornor Road, Elkton, Maryland 21921</b>				20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Old Bohemia Manor Cemetery</b>				20c. Location - City or Town, State <b>Chesapeake City, Maryland</b>				21. Signature of Funeral Service Licensee <b>William L. King Jr.</b>	
	22. Name and Address of Facility <b>Fellows, Helfenbein &amp; Newnam Funeral Home, P.A. 226 East Main Street, Cecilton, Maryland 21913</b>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Prostate CA</b> Due to (or as a consequence of): <b>DM II</b> Due to (or as a consequence of): <b>HTN</b> Due to (or as a consequence of): <b>Cerebrovascular disease</b>				Approximate Interval Between Onset and Death <b>20 yr</b> <b>20</b> <b>20</b> <b>10</b>	
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>Jose Ma</b>				29c. License number <b>044716</b>	
	29d. Date signed (Month, Day, Year) <b>6/24/96</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>111 W. High st Elkton MD</b>				31. Date filed (Month, Day, Year) <b>JUN 20 '96</b>	
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature <b>Julia Davidson-Rendall</b>				33. State Registrar <b>Dr. Jose Ma</b>				34. State Registrar <b>Dr. Jose Ma</b>	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



96 25857

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>TINA MARIE RATLIFF</b>				2. DATE OF DEATH MONTH DAY YEAR <b>June 20, 1996</b>		3. TIME OF DEATH <b>1:30 a.m.</b>	
4. SOCIAL SECURITY NUMBER <b>214-80-9340</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>27</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>January 29, 1969</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Chestertown, Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>1522 Roe-Ingleside Road (At Home)</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Ingleside</b>	
9c. COUNTY OF DEATH <b>Queen Annes</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Queen Annes</b>	
10c. CITY, TOWN OR LOCATION <b>Ingleside</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>1522 Roe-Ingleside Road</b>	
10f. ZIP CODE <b>21644</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Postmaster Relief</b>				16b. KIND OF BUSINESS/INDUSTRY <b>U.S. Postal Service</b>			
17. FATHER'S NAME (First, Middle, Last) <b>James Meredith</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary JoAnn Faber</b>			
19a. INFORMANT'S NAME (Type/Print) <b>David B. Ratliff, Sr./Husband</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1522 Roe-Ingleside Road, Ingleside, Maryland 21644</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Church Hill Cemetery/June 22, 1996</b>			
20c. LOCATION — City or Town, State <b>Church Hill, Maryland</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thomas K. Helfenbein</i>			
22. NAME AND ADDRESS OF FACILITY <b>Fellows, Helfenbein &amp; Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sarcoma with Pulmonary Metastasis</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Anemia Hypomagnesemia Malnutrition</b>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY <b>M</b>			
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, tactory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael Lees</i>			
29c. LICENSE NUMBER <b>042005</b>				29d. DATE SIGNED (Month, Day, Year) <b>6/20/96</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Michael Lees M.D. Easton, Maryland 21601</b>							
31. DATE FILED (Month, Day, Year) <b>JUN 21 '96</b>				32. REGISTRAR'S SIGNATURE <i>Johia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 25858

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret A. Ready				2. Date of Death Month Day Year August 9 1996				3. Time of Death 6:30AM	
	4a. Facility Name (If not institution, give street and number) Meridian Health Care Center, Spa Creek				4b. City, Town, or Location of Death Annapolis				4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 577-03-1674		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) Jan 24 1911		9. Birthplace (State or Foreign Country) Washington, D.C.	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State 10b. County		10c. City, Town or Location Washington, D.C.				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 3983 Alabama Avenue, S.E.				10f. Zip Code 20020		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 Collage (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary				18b. Kind of Business/Industry Railway Express			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Bartholomew M. Ready				18. Mother's Name (First, Middle, Maiden Surname) Agnes Sauter					
	19a. Informant's Name/Relationship (Type, Print) William F. Graves-Nephew				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2825 Penny Pond Lane Annapolis, Maryland 21401					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet Cemetery August 10 1996 Washington, D.C.		20c. Location - City or Town, State					
	21. Signature of Funeral Service Licensee <i>James M. Taylor</i>		22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Pneumonia with pleural effusion</i>								Approximate Interval Between Onset and Death <i>recent</i>	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. <i>—</i> c. <i>—</i> d. <i>—</i>									
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Undernutrition</i> <i>Congestive heart failure</i>									
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								27b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
Medical Certification: To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
	28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Charles W. Kinzer</i>		29c. License number D05928		29d. Date signed (Month, Day, Year) August 20, 1996			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles W. Kinzer, M.D. 2003 Medical Parkway Suite 100 Annapolis, MD 21401		31. Date filed (Month, Day, Year) AUG 20 1996		32. Registrar's Signature <i>Julia Davidson-Rendall</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25859

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mariano M. Sotelo

2. Date of Death

Month Day Year  
Aug. 4, 1996

3. Time of Death

1:30 P.M.

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

5. Social Security Number

569-42-7631

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

96 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 16, 1900

9. Birthplace (State or Foreign Country)

Philippines

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Prince George's10c. City, Town or Location  
Clinton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6108 Hellen Lee Drive

10f. Zip Code

20735

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Filipino

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

House Boy - Cook

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

Raymondo Sotelo

18. Mother's Name (First, Middle, Maiden Surname)

Juana Mayo

19a. Informant's Name/Relationship (Type, Print)

Faustina G. Mayo - Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6108 Hellen Lee Dr. Clinton, Md. 20735

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Resurrection Cemetery 8/7/96

Date

20c. Location - City or Town, State

Clinton, Maryland

21. Signature of Funeral Service Licensee

Robert P. Kalas

22. Name and Address of Facility

George P. Kalas Funeral Home  
6160 Oxon Hill Rd. Oxon Hill, Md. 2074523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. SEPSIS

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. GANGRENE RIGHT LEG

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

CARDIAC ARRHYTHMIA RAPID ATRIAL  
FIBRILLATION

ACUTE RENAL INSUFFICIENCY

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

N/A

28b. Time of Injury

N/A

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

N/A

28d. Describe how injury occurred

N/A

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Gerardo M. Garcia

29c. License number

D17799

29d. Date signed (Month, Day, Year)

8/5/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GERARDO M. GARCIA 6510 KENILWORTH AV. RIVERDALE MD 20737

31. Date filed (Month, Day, Year)

AUG 07 1996

32. Registrar's Signature

John Andrew Rader

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1947-1948

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25860

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Florence Margaret Smith				2. Date of Death Month Day Year August 5, 1996		3. Time of Death 5:00 am		
	4a. Facility Name (If not Institution, give street and number) Hillhaven Nursing Center				4b. City, Town, or Location of Death Adelphi		4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 048-20-5752		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 19, 1907	9. Birthplace (State or Foreign Country) Massachusetts	
	Usual Residence of Decedent								
10a. State MD		10b. County Prince George's		10c. City, Town or Location Adelphi			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 3210 Powder Mill Road				10f. Zip Code 20783		10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerical Work		16b. Kind of Business/Industry Private Sector			
17. Father's Name (First, Middle, Last) Thomas E. Spellacy				18. Mother's Name (First, Middle, Maiden Surname) Margaret Brien					
19a. Informant's Name/Relationship (Type, Print) Edward T. Spellacy / Brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6904 17th Avenue, Hyattsville, Maryland 20783					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		20c. Location - City or Town, State Brentwood, Maryland		20d. Date 8/08/1996	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Aspiration Due to (or as a consequence of): b. Dementia Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 24 Hours 2 years	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier 				29c. License number S 25009		29d. Date signed (Month, Day, Year) August 6, 1996			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Charles M. Benner, M.D. 11251 Lockwood Drive, Silver Spring, MD 20901									
31. Date filed (Month, Day, Year) AUG 07 1996				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the document is a list of names and addresses of the members of the committee. The names are listed in alphabetical order, and the addresses are given below each name. The list includes names such as Mr. J. H. Smith, Mr. W. B. Jones, and Mr. C. D. Brown.

2. The second part of the document is a list of the names of the members of the committee who have been elected to the office of chairman and vice-chairman. The names are listed in alphabetical order, and the offices are given below each name. The list includes names such as Mr. J. H. Smith, Mr. W. B. Jones, and Mr. C. D. Brown.

3. The third part of the document is a list of the names of the members of the committee who have been elected to the office of secretary and treasurer. The names are listed in alphabetical order, and the offices are given below each name. The list includes names such as Mr. J. H. Smith, Mr. W. B. Jones, and Mr. C. D. Brown.

4. The fourth part of the document is a list of the names of the members of the committee who have been elected to the office of clerk and recorder. The names are listed in alphabetical order, and the offices are given below each name. The list includes names such as Mr. J. H. Smith, Mr. W. B. Jones, and Mr. C. D. Brown.

5. The fifth part of the document is a list of the names of the members of the committee who have been elected to the office of auditor and comptroller. The names are listed in alphabetical order, and the offices are given below each name. The list includes names such as Mr. J. H. Smith, Mr. W. B. Jones, and Mr. C. D. Brown.

6. The sixth part of the document is a list of the names of the members of the committee who have been elected to the office of assessor and collector. The names are listed in alphabetical order, and the offices are given below each name. The list includes names such as Mr. J. H. Smith, Mr. W. B. Jones, and Mr. C. D. Brown.

7. The seventh part of the document is a list of the names of the members of the committee who have been elected to the office of judge and justice. The names are listed in alphabetical order, and the offices are given below each name. The list includes names such as Mr. J. H. Smith, Mr. W. B. Jones, and Mr. C. D. Brown.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 25861

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lancelot Silvera</b>				2. Date of Death Month Day Year <b>July 30, 1996</b>		3. Time of Death <b>10:48 PM</b>	
	4e. Facility Name (If not institution, give street and number) <b>5613 35th place</b>				4b. City, Town, or Location of Death <b>Hyattsville</b>		4c. County of Death <b>Prince Georges</b>	
Funeral Director	5. Social Security Number <b>220-04-4863</b>		6. Sex <b>1</b> M <b>2</b> F		7. Age (In yrs. last birthday) <b>47</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov. 14, 1948</b>	
	9. Birthplace (State or Foreign Country) <b>St. Thomas, Jama</b>		10a. State <b>MD</b>		10b. County <b>Prince Georges</b>		10c. City, Town or Location <b>Hyattsville</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <b>1</b> Yes <b>2</b> No		10e. Street and Number <b>5613 35th Place</b>		10f. Zip Code <b>20782</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify <b>Jamican</b>		14. Race - American Indian, Black, White, etc. Specify: <b>Jamican</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Support Services</b>		16b. Kind of Business/Industry <b>Law Firm</b>			
	17. Father's Name (First, Middle, Last) <b>Oswald Mullings</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Hazle Williams</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Lois Joyner Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5613 35th Place, Hyattsville, MD 20782</b>					
	20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Ft. Lincoln Cemetery</b>		20c. Date <b>8-5-96</b>		20d. Location - City or Town, State <b>Brentwood, MD</b>	
	21. Signature of Funeral Service Licensee <b>J. P. Marshall</b>		22. Name and Address of Facility <b>Marshall's Funeral Home, Inc. 4217 9th St. NW, Wash DC 20011</b>					
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>CARDIOMYOPATHY</b> <b>CONGESTIVE HEART FAILURE</b> <b>VENTRICULAR TACHYARRHYTHMIAS</b> <b>HEPATIC FAILURE</b>						Approximate Interval Between Onset and Death <b>4 yrs</b> <b>4 yrs</b> <b>6 months</b> <b>1 month</b>	
	23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown							
	24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No						24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No		26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)					
	27. Manner of Death <b>1</b> Natural <b>2</b> Accident <b>3</b> Suicide <b>4</b> Homicide <b>5</b> Pending investigation <b>6</b> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No	
			28d. Describe how injury occurred					
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>VP Singh Attend Phys.</b>		29c. License number <b>Q 19897</b>		29d. Date signed (Month, Day, Year) <b>8.29.96</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>V. SINGH 7209 A HANOVER PARKWAY GREGG BELT MD 20777</b>		31. Date filed (Month, Day, Year) <b>AUG 06 1996</b>		Registrar's Signature <b>J. P. Marshall</b>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar

SILVERA  
LANCLOT



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25862

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ANZOL, M. SIMS

2. Date of Death

Month  
08Day  
02Year  
96

3. Time of Death

8:45a.m.

4a. Facility Name (If not Institution, give street and number)

Prince Georges General Hospital

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

P.G.

Funeral  
Director

5. Social Security Number

462-72-3176

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

52

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
04/24/44

9. Birthplace (State or Foreign Country)

Texas

Usual Residence of Decedent

10a. State

MD

10b. County

P.G.

10c. City, Town or Location

District Heights

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2121 Harwood Rd

10f. Zip Code

20747

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 1962-198313. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Meter Installer

16b. Kind of Business/Industry

PEPCO

17. Father's Name (First, Middle, Last)

Clarence Sims Sr.

18. Mother's Name (First, Middle, Maiden Summa)

Sadie Hubbard

19a. Informant's Name/Relationship (Type, Print)

Erniw Sibley Sims

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2121 Harwood RD. Dist. Hgts.Md.20747

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

MD. Veteran's Ce,

Date

8/12/96

20c. Location - City or Town, State

Cheltenham, MD.

21. Signature of Funeral Service Licensee

Prince Edwards

22. Name and Address of Facility

Hodges and Edwards

3910 Silver Hill RD. Suitland, Md.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Cardiopulmonary Arrest

Due to (or as a consequence of):

b. Bilateral Pulmonary Embolus

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. B. 2 MD

29c. License number

D46266

29d. Date signed (Month, Day, Year)

August 8, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fitzgerald Birmingham MD

Prince Georges Hospital, Cheverly Md.

State  
Registrar

31. Date filed (Month, Day, Year)

AUG 09 1996

32. Registrar's Signature

John Anderson

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



96 25863

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Lucille M. STEWART</u>				2. DATE OF DEATH MONTH <u>July</u> DAY <u>28</u> YEAR <u>96</u>		3. TIME OF DEATH <u>10:18 A.M.</u>	
4. SOCIAL SECURITY NUMBER <u>242-01-0293</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <u>86</u> YRS.	7. DATE OF BIRTH (Month, Day, Year) <u>11-13-1909</u>		8. BIRTHPLACE (State or Foreign Country) <u>North Carolina</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>WASHINGTON ADVENTIST HOSPITAL</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>TAKOMA PARK</u>		9c. COUNTY OF DEATH <u>Prince George</u>	
RESIDENCE OF DECEDENT							
10a. STATE <u>D.C.</u>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <u>WASHINGTON</u>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <u>1315 Peabody St, N.W.</u>				10f. ZIP CODE <u>20011</u>		10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>BLACK</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>3</u> College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Housewife</u>		16b. KIND OF BUSINESS/INDUSTRY <u>OWN Home</u>			
17. FATHER'S NAME (First, Middle, Last) <u>Henry Merritt</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Callie West</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Sherry McCoy</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>13015 Ingleside Dr, Beltsville, Md 20705</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Glenwood Cemetery 8-3-96</u>		20c. LOCATION — City or Town, State <u>Washington, D.C.</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Paul de Mateo</u>				22. NAME AND ADDRESS OF FACILITY <u>Universal Mortuary Inc. 411 Kennedy St, N.W. Washington, D.C.</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <u>Respiratory arrest</u>					Approximate interval Between Onset and Death <u>5 mins</u>
		b. <u>Arrhythmia</u>					<u>3 hrs</u>
		c. <u>Cerebrovascular accident</u>					<u>12 hrs</u>
		d. <u>Left Femoral Fracture</u>					<u>3 days</u>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <u>July 24 96</u>		28b. TIME OF INJURY <u>0800 M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <u>Fell</u>				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <u>Nursing Home</u>			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <u>4922 LaSalle Rd Hyattsville Md</u>							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>John Tauber MD</u>				29c. LICENSE NUMBER <u>D08546</u>		29d. DATE SIGNED (Month, Day, Year) <u>July 29 96</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>John Tauber 8218 Wisconsin Ave Bethesda Md</u>							
31. DATE FILED (Month, Day, Year) <u>AUG 05 1996</u>		32. REGISTRAR'S SIGNATURE <u>John Tauber-Randall</u>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed without delay after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25864

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Viola E. Stefl

2. Date of Death

Month Day Year  
July 29, 1996

3. Time of Death

6:20 am

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

172-01-0128

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

PA

10b. County

Cumberland

10c. City, Town or Location

Mechanicsburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4837 East Trindle Road

10f. Zip Code

17055

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Bookkeeper

16b. Kind of Business/Industry

Providence Hospital

17. Father's Name (First, Middle, Last)

William A. Fleager

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Whipperman

19a. Informant's Name/Relationship (Type, Print)

Carole A. Ballard/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3930 Blackburn Road, Apt. 44, Burtonsville, MD 20866

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 8/05/1996 Alexandria, Virginia

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

W. B. Gerson

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.

4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Cardiopulmonary Arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient3 ☒ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Peter T. Katsiyannis

29c. License number

D0050936-MD

29d. Date signed (Month, Day, Year)

8/3/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Peter T. Katsiyannis, M.D. 3001 Hospital Drive, Cheverly, Maryland 20785

State  
Registrar

31. Date filed (Month, Day, Year)

AUG 08 1996

32. Registrar's Signature

John A. Russell

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25865

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Frederick Stack				2. Date of Death Month Day Year Aug 16, 1996		3. Time of Death 2:26 P			
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital Center				4b. City, Town, or Location of Death Clinton		4c. County of Death Prince George's			
Funeral Director	5. Social Security Number 220-07-2452		6. Sex 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F X	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept 4, 1917	9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Prince George's		10c. City, Town or Location District Heights		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 2116 Scott Key Drive				10f. Zip Code 20747		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1945-46		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Drive/Delivery Man		16b. Kind of Business/Industry REA Express			
	17. Father's Name (First, Middle, Last) Frederick Stack				18. Mother's Name (First, Middle, Maiden Surname) Virginia Saubrich					
	19a. Informant's Name/Relationship (Type, Print) Elizabeth P. Stack (WIFE)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2116 Scott Key Drive, District Heights, Md 20747					
	20a. Method of Disposition X Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery		20c. Location - City or Town, State Cheltenham, Maryland		20d. Date Aug 20, 1996			
	21. Signature of Funeral Service Licensee [Signature]				22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. BILATERAL PNEUMONIA Due to (or as a consequence of): b. GRAM NEGATIVE RODS Due to (or as a consequence of): c. CHRONIC LYMPHOCYTIC LYMPHOMA Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 8 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Victor E. Herry MD		29c. License number D20986		29d. Date signed (Month, Day, Year) 8-16-96		29e. Name and address of person who completed cause of death (Item 23a) (Type, Print) VICTOR E. HERRY MD 9131 PISCATAWAY Rd CLINTON MD 20735		
31. Date filed (Month, Day, Year) AUG 20 1996		32. Registrar's Signature [Signature]								

Baltimore, Maryland 21215-0020

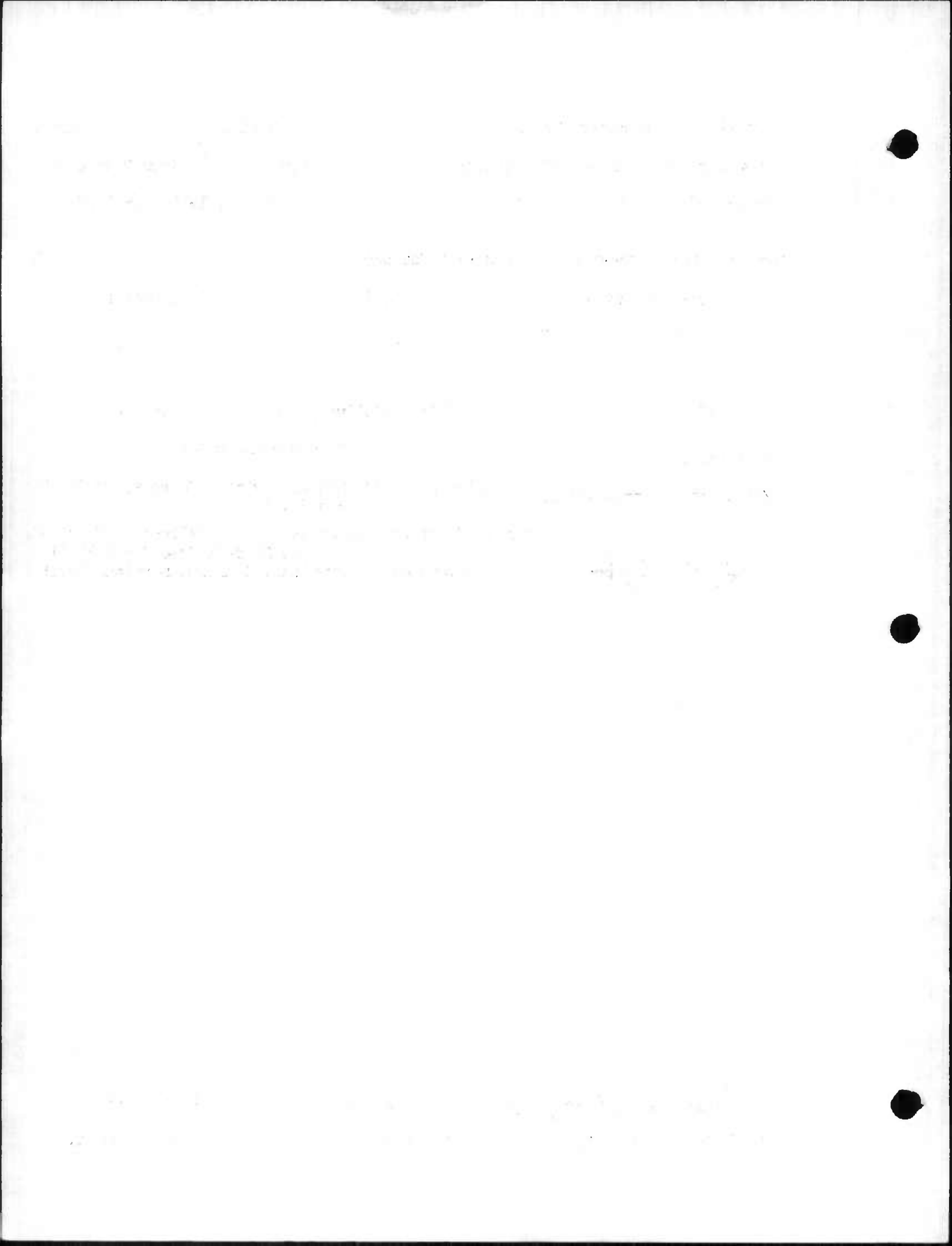
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25866

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>KEVIN SCOTT SIMMS</b>						2. Date of Death Month Day Year <b>Aug. 11, 1996</b>		3. Time of Death <b>05:45 hrs.</b>	
	4e. Facility Name (If not institution, give street and number) <b>32066 Old Ocean City Rd.</b>						4b. City, Town, or Location of Death <b>Parsonsborg</b>		4c. County of Death <b>Wicomico</b>	
Funeral Director	5. Social Security Number <b>216-94-8302</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>20</b> Yrs.		If Under 1 Year Months Days <b>20</b>		8. Date of Birth (Month, Day, Year) <b>Sept. 13, 1975</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>									
Usual Residence of Decedent										
10a. State <b>Md.</b>		10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Parsonsborg</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>32066 Old Ocean City Rd.</b>						10f. Zip Code <b>21849</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>				16b. Kind of Business/Industry <b>Construction</b>		
17. Father's Name (First, Middle, Last) <b>Charles Edward Simms</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Darlene Belle Moore</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Charles E. Simms Jr.</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>32066 Old Ocean City Rd., Parsonsborg, Md. 21849</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parsons Cemetery</b>		Date <b>8/14/96</b>		20c. Location - City or Town, State <b>Salisbury, Md.</b>		
21. Signature of Funeral Service Licensee <i>Ewald C. Sauer</i>						22. Name and Address of Facility <b>Bounds Funeral Home, Salisbury, Md. 21804</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. acute lymphocytic leukemia</b> Due to (or as a consequence of):  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Piece of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <i>Joseph A. Grasso MD</i>						29c. License number <b>020507</b>		29d. Date signed (Month, Day, Year) <b>8/12/96</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>145 E. Carroll St SALISBURY MD 21801 Joseph A. GRASSO</b>										
31. Date filed (Month, Day, Year) <b>AUG 12 1996</b>						32. Registrar's Signature <i>John Davidson-Randall</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or item 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25867

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>John B Shaw</i> REV. JOHN B. SHAW				2. Date of Death Month <i>07</i> Day <i>16</i> Year <i>96</i>		3. Time of Death <i>2000</i>	
	4a. Facility Name (If not institution, give street and number) <i>University of Maryland Hospital</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>Baltimore</i>	
Funeral Director	5. Social Security Number <i>187-24-1067</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>66</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>04/21/30</i>	9. Birthplace (State or Foreign Country) <i>Crossroads, PA</i>
	Usual Residence of Decedent							
10a. State <i>Delaware</i>		10b. County <i>Sussex</i>		10c. City, Town or Location <i>Milton</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <i>RD 1, Box 77</i>				10f. Zip Code <i>19968</i>		10g. Citizen of What Country? <i>U.S.A.</i>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>5+</i> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Clergy</i>			16b. Kind of Business/Industry <i>Christian Ministry</i>	
17. Father's Name (First, Middle, Last) <i>S. Benjamin Shaw</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Bertha S. Raybuck</i>				
19a. Informant's Name/Relationship (Type, Print) <i>Gladys H. Shaw/ Wife</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>RD 1, Box 77, Milton, DE 19968</i>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Eastern Shore Crematorium</i>		Date <i>07/19/96</i>		20c. Location - City or Town, State <i>Lewes, Delaware</i>		
21. Signature of Funeral Service Licensee <i>Keith Parsell</i>				22. Name and Address of Facility <i>Parsell Atkins &amp; Lodge Funeral Home 1449 Kings Highway, Lewes, DE 19958</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>a. Myocardial Infarction</i> Due to (or as a consequence of):  <i>b.</i> Due to (or as a consequence of):  <i>c.</i> Due to (or as a consequence of):  <i>d.</i>								Approximate Interval Between Onset and Death <i>20 min</i>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>John B. Shaw MD</i>		29c. License number <i>10246</i>		29d. Date signed (Month, Day, Year) <i>7/16/96</i>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>215. Greene Street Balto, MD 21207</i>								
31. Date filed (Month, Day, Year) <i>AUG 12 1996</i>				32. Registrar's Signature <i>John B. Shaw</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



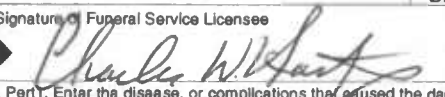
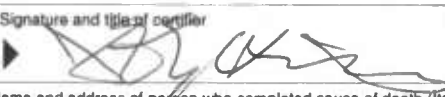
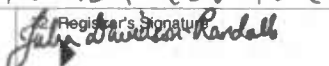
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25868

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GOLDIE A. Spahr</b>				2. Date of Death Month <b>Aug</b> Day <b>10</b> Year <b>1996</b>		3. Time of Death <b>1441</b>	
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>	
Funeral Director	5. Social Security Number <b>186-50-1097</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>82</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JUN. 27, 1914</b>	
	9. Birthplace (State or Foreign Country) <b>PENNSYLVANIA</b>		10a. State <b>PA</b>		10b. County <b>YORK</b>		10c. City, Town or Location <b>DOVER</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>6460 OLD CARLISLE ROAD</b>		10f. Zip Code <b>17315</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>HOMEMAKER</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>OWN HOME</b>		16b. Kind of Business/Industry <b>OWN HOME</b>				
17. Father's Name (First, Middle, Last) <b>RUSSELL DILLER</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ESTHER DeARMAN</b>				
19a. Informant's Name/Relationship (Type, Print) <b>DELORES A. JOHNSON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>RT. 2 BOX 2B, SELBYVILLE, DE 19975</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>SALEM UNION CEMETERY</b>		20c. Date <b>8/14/96</b>		20d. Location - City or Town, State <b>DOVER, PA</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>HASTINGS FUNERAL HOME, SELBYVILLE, DE</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Myocardial Infarction</b> Due to (or as a consequence of): <b>b. Coronary Artery Disease</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Approximate Interval Between Onset and Death <b>Days</b> <b>years</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number <b>MD D36783</b>		29d. Date signed (Month, Day, Year) <b>8/10/96</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Jeffrey H. Betherton M.D., PRMC, SALISBURY, MD.</b>								
31. Date filed (Month, Day, Year) <b>AUG 14 1996</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25869

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Wayne Neale Schulze

2. Date of Death

August 15 1996

3. Time of Death

10 AM

4a. Facility Name (If not institution, give street and number)

2618 Chambers Place

4b. City, Town, or Location of Death

Lusby

4c. County of Death

Calvert

Funeral  
Director

5. Social Security Number

214 36 3621

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

58

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

December 19 1937

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Calvert

10c. City, Town or Location

Lusby

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2618 Chambers Place

10f. Zip Code

20657

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: unk

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

18e. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Postal worker

16b. Kind of Business/Industry

US Government

17. Father's Name (First, Middle, Last)

Everett Elwood Schulze

18. Mother's Name (First, Middle, Maiden Surname)

Ignata Cecelia Lechliden

19a. Informant's Name/Relationship (Type, Print)

Lori Kocur

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19500 Luhn St. Poolesville Md 20837

20e. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan August 18 1996

Date

20c. Location - City or Town, State

Alexandria Virginia

21. Signature of Funeral Service Licensee

B. Rausch

22. Name and Address of Facility

Rausch Funeral Home

4405 Broomes Is. Rd. Port Republic Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. atherosclerotic heart disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. hypertension

Due to (or as a consequence of):

c. alcoholism

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier

Sylvia Batong, M.D.

29c. License number

D 43306

29d. Date signed (Month, Day, Year)

August 16, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Sylvia Batong, M.D. 11845 H.G. Trueman Rd. Lusby Maryland 20657

31. Date filed (Month, Day, Year)

AUG 19 1996

32. Registrar's Signature

S. Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

in the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25870

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MILDRED EVA SNYDER				2. Date of Death Month Day Year AUGUST 13, 1996		3. Time of Death 23:35	
	4a. Facility Name (If not institution, give street and number) CALVERT MEMORIAL HOSPITAL				4b. City, Town, or Location of Death PRINCE FREDERICK		4c. County of Death CALVERT	
Funeral Director	5. Social Security Number 198-28-3580	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 61 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) MAY 10, 1935	9. Birthplace (State or Foreign Country) SHICKSKINNY, PA.	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MARYLAND	10b. County CALVERT	10c. City, Town or Location LUSBY			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 12070 SUSAN LANE			10f. Zip Code 20657		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10TH College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PACKER			16b. Kind of Business/Industry POTATO CHIP CO.		
	17. Father's Name (First, Middle, Last) PEARL APPELBY				18. Mother's Name (First, Middle, Maiden Surname) CLARA EDNA SMITH			
	19a. Informant's Name/Relationship (Type, Print) CHARLENE M. SKATES				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS #10			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) METROPOLITAN CREMATORY 8-15-96 ALEX., VA.		Date		20c. Location - City or Town, State	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility RAYMOND FUNERAL HOME DUNKIRK, MARYLAND 20754			
	23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARDIOPULMONARY ARREST Due to (or as a consequence of): b. LUNG CANCER Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
	Approximate Interval Between Onset and Death 10 MONTHS							
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE PULMONARY DISEASE						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 				29c. License number DU4618		29d. Date signed (Month, Day, Year) 8/15/96	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marcia Sherman MD 120 Hospital Rd Prince Frederick MD 20678							
State Registrar	31. Date filed (Month, Day, Year) AUG 16 1996		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25871

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25872

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) IRYLL EDDY SMITH			2. Date of Death Month: AUGUST 13 Day: 13 Year: 1996		3. Time of Death 12:25 am	
	4a. Facility Name (If not institution, give street and number) Calvert County Nursing Center			4b. City, Town, or Location of Death Prince Frederick		4c. County of Death Calvert	
Funeral Director	5. Social Security Number 095 01 6688		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 5, 1913
	9. Birthplace (State or Foreign Country) Illinois						
To Be Completed by Funeral Director	Usual Residence of Decedent						
	10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Deale		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 5934 Rockhold Drive			10f. Zip Code 20751		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1941-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Automotive Parts Sales Manag.		16b. Kind of Business/Industry Automotive		
	17. Father's Name (First, Middle, Last) Carl Oren Smith, Sr.			18. Mother's Name (First, Middle, Maiden Surname) Carrie Barbara Eddy			
	19a. Informant's Name/Relationship (Type, Print) Hazel M. Smith / wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as # 10 above			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MD Veterans Cemetery		Data 8/16/96	20c. Location - City or Town, State Cheltenham, MD	
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD 20736			
	23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive heart failure Due to (or as a consequence of): Cardiomyopathy Due to (or as a consequence of): Diabetes Mellitus Due to (or as a consequence of): Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia						
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 			29c. License number D37588		29d. Date signed (Month, Day, Year) 8-13-96		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 135 W. Jones Beach Rd #109 Prince Georges 20678							
State Registrar	31. Date filed (Month, Day, Year) AUG 15 1996			32. Registrar's Signature J. Davidson-Randall			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene

96 25873

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>William Jeter Savage, Jr.</b>				2. Date of Death Month Day Year <b>June 25, 1996</b>		3. Time of Death <b>Unknown</b>	
	4a. Facility Name (If not institution, give street and number) <b>7101 Church Hill Road (At Home)</b>				4b. City, Town, or Location of Death <b>Chestertown</b>		4c. County of Death <b>Queen Anne's</b>	
Funeral Director	5. Social Security Number <b>215-18-4028</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>February 29, 1920</b>	
	9. Birthplace (State or Foreign Country) <b>Virginia</b>		10a. State <b>Maryland</b>		10b. County <b>Queen Anne's</b>		10c. City, Town or Location <b>Chestertown</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>7101 Church Hill Road</b>		10f. Zip Code <b>21620</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 6</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Property Caretaker</b>		16b. Kind of Business/Industry <b>Someone else's home</b>		17. Father's Name (First, Middle, Last) <b>William Jeter Savage, Sr.</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>Virginia Lee Parks</b>		19a. Informant's Name/Relationship (Type, Print) <b>Marie McGhee/Sister</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14518 Shirley Bohn Road, Mt. Airy, Maryland 21771</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chester Cemetery/June 27, 1996</b>		20c. Location - City or Town, State <b>Chestertown, Maryland</b>		21. Signature of Funeral Service Licensee <i>Gay B. Fellows</i>		22. Name and Address of Facility <b>Fellows, Helfenbein &amp; Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620</b>	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Heart Disease</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>		Approximate Interval Between Onset and Death <b>about 7 weeks</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Ralph E. Libby</i>	
	29c. License number <b>005754</b>		29d. Date signed (Month, Day, Year) <b>6-26-96</b>		30. Name and address of person who completed cause of death (Item 23) (Type, Print) <b>Ralph E. Libby, MD; 204 Medican Center Road; Grasonville, Md 21638</b>		31. Date filed (Month, Day, Year) <b>JUN 28 '96</b>	
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature <i>Julia Davidson-Randall</i>		33. Date of Death (Month, Day, Year) <b>June 25, 1996</b>		34. Date of Birth (Month, Day, Year) <b>February 29, 1920</b>		35. Date of Death (Month, Day, Year) <b>June 25, 1996</b>	
	36. Date of Death (Month, Day, Year) <b>June 25, 1996</b>		37. Date of Birth (Month, Day, Year) <b>February 29, 1920</b>		38. Date of Death (Month, Day, Year) <b>June 25, 1996</b>		39. Date of Birth (Month, Day, Year) <b>February 29, 1920</b>	

Baltimore, Maryland 21215-0020

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State of Maryland / Department of Health and Mental Hygiene

96 25874

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Harry Augustine Smith Sr.				2. Date of Death Month June 20, Day 1996 Year		3. Time of Death 1535	
	4a. Facility Name (If not institution, give street and number) Kent & Queen Anne's Co. Hospital Inc				4b. City, Town, or Location of Death CHestertown		4c. County of Death Kent	
Funeral Director	5. Social Security Number 212-12-3828		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) March 22, 1909	
	9. Birthplace (State or Foreign Country) Chestertown, MD		10a. State Maryland		10b. County Kent		10c. City, Town or Location Chestertown	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 8674 Elm Road		10f. Zip Code 21620		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+)		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter		16b. Kind of Business/Industry Carpenter's Union			
	17. Father's Name (First, Middle, Last) William Henry Smith				18. Mother's Name (First, Middle, Maiden Surname) Irene H. Fields			
	19a. Informant's Name/Relationship (Type, Print) Harry A. Smith, Jr./Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 142, Worton, Maryland 21678			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chester Cemetery/June 24, 1996		Date June 24, 1996		20c. Location - City or Town, State Chestertown, Maryland	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Fellows, Helfenbein & Newman Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cerebral hemorrhage Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hypertension, Cerebrovascular disease							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
Medical Certification: To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 		29c. License number D00354		29d. Date signed (Month, Day, Year) 6/21/96			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. Gottfried Baumann, M.D. 100 Brown St. - Chestertown, Md. 21620							
State Registrar	31. Date filed (Month, Day, Year) JUN 21 '96		32. Registrar's Signature 					



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State of Maryland / Department of Health and Mental Hygiene

96 25875

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Genevieve Clair Snyder</b>						2. Date of Death Month Day Year <b>August 13 1996</b>		3. Time of Death <b>12:06PM</b>			
	4a. Facility Name (If not Institution, give street and number) <b>Anne Arundel Medical Center</b>						4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>			
Funeral Director	5. Social Security Number <b>055-10-5363</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>88</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 8 1908</b>		9. Birthplace (State or Foreign Country) <b>New York</b>			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Annapolis</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number <b>1138 River Boat Court</b>				10f. Zip Code <b>21401</b>		10g. Citizen of What Country? <b>United States</b>					
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Operator</b>			16b. Kind of Business/Industry <b>Telephone Company</b>				
	17. Father's Name (First, Middle, Last) <b>John Schaffer</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Genevieve Malloy</b>					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Sally English</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1138 River Boat Court Annapolis, MD 21401</b>							
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Et. Lincoln Crematory 8/16/96</b>		20c. Location - City or Town, State <b>Brentwood, Maryland</b>					
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401</b>							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Respiratory Arrest</b> Due to (or as a consequence of): b. <b>Left sided pneumonia</b> Due to (or as a consequence of): c. <b>Impaired Swallowing with Aspiration</b> Due to (or as a consequence of): d. <b>Previous Cerebral Vascular Accident</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death <b>10 minutes</b> <b>2 weeks</b> <b>2 months</b> <b>2 months</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Multi-infarct Dementia</b>										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>[Signature]</i> <b>MD</b>				29c. License number <b>D32654</b>		29d. Date signed (Month, Day, Year) <b>August 13, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John Serlemitsos 1509 Ritchie Highway, Arnold, MD 21012</b>												
31. Date filed (Month, Day, Year) <b>AUG 16 1996</b>				32. Registrar's Signature <i>[Signature]</i>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25876

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Glenn D. Sterner				2. Date of Death Month Day Year July 26, 1996		3. Time of Death 1:30 PM	
	4a. Facility Name (If not institution, give street and number) Chesapeake Manor Health Care Center				4b. City, Town, or Location of Death Arnold		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 190-26-6278		8. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 24, 1902	9. Birthplace (State or Foreign Country) Pennsylvania
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Arnold			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 305 College Parkway				10f. Zip Code 21012		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12+ College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pressman		16b. Kind of Business/Industry Printer		
	17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)			
	19a. Informant's Name/Relationship (Type, Print) Barbara Bunting/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1806 Dreams Landing Way Annapolis, MD 21401			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		Date 7-27-96		20c. Location - City or Town, State Baltimore, MD	
	21. Signature of Funeral Service Licensee <i>James E. Barranco</i>				22. Name and Address of Facility Barranco and Sons Funeral Home 495 Ritchie Hwy. Severna Park, MD 21146			
	23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Cerebral &amp; the Colon</i> Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Whymae M. Attending Doctor</i>				29c. License number D 21684		29d. Date signed (Month, Day, Year) 7-27-96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C.V. CYRIAC, MD 1600 CRAIN HWY #106, GLENBURIA, MD 21061								
31. Date filed (Month, Day, Year) AUG 15 1996				32. Registrar's Signature <i>John Davidson-Randall</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 25877

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

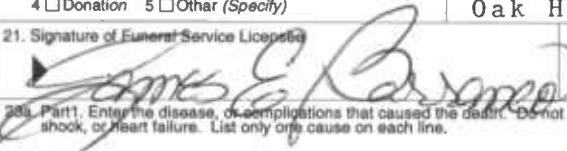

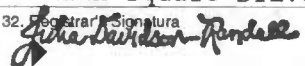
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Raymond Earl SUTER</b>				2. Date of Death Month <b>August</b> Day <b>6</b> Year <b>1996</b>		3. Time of Death <b>4:55a.m.</b>	
4a. Facility Name (If not institution, give street and number) <b>Franklin Square Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>Baltimore</b>	
5. Social Security Number <b>317-26-3404</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>66</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct. 2, 1929</b>	
9. Birthplace (State or Foreign Country) <b>IN</b>		10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Arnold</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>293 Yale Court</b>		10f. Zip Code <b>21012</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1948-52</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12+</b> College (1-4 or 5+) <b>12+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Senior Research Engineer</b>		16b. Kind of Business/Industry <b>Aerospace</b>		17. Father's Name (First, Middle, Last) <b>Allen Hamilton Suter</b>	
18. Mother's Name (First, Middle, Maiden Surname) <b>Sara Jane McNeely</b>		19a. Informant's Name/Relationship (Type, Print) <b>Alma M. Suter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>293 Yale Court, Arnold, MD 21012</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Oak Hill Memorial</b>		20c. Location - City or Town, State <b>San Jose, California</b>		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Barranco &amp; Sons Funeral Home</b> <b>495 Ritchie Highway Severna Park, MD</b>	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Hypoxemia</b> Due to (or as a consequence of): <b>Ischemic cardiomyopathy</b>  <b>b. Ischemic cardiomyopathy</b> Due to (or as a consequence of):  <b>c. Ischemic cardiomyopathy</b> Due to (or as a consequence of):  <b>d. Ischemic cardiomyopathy</b> Due to (or as a consequence of):		Approximate Interval Between Onset and Death <b>4 minutes</b> <b>20 years</b>		23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 	
29c. License number <b>R1917</b>		29d. Date signed (Month, Day, Year)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. John Kim 9000 Franklin Square Drive Baltimore, Maryland 21237</b>		31. Date filed (Month, Day, Year) <b>AUG 15 1996</b>	
32. Registrar's Signature 							

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25878

## Certificate of Death

Reg. No.

|  |   |  |   |                                |   |
|--|---|--|---|--------------------------------|---|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedant's Name (First, Middle, Last)<br>DOROTHY HAZEL   |  | 2. Date of Death<br>Month Day Year<br>August 6 1996   |                                | 3. Time of Death<br>2200  |
|  | 4a. Facility Name (If not institution, give street and number)<br>PENINSULA REGIONAL MEDICAL CENTER   |  | 4b. City, Town, or Location of Death<br>SALISBURY   |                                | 4c. County of Death<br>WICOMICO   |
| Funeral<br>Director  | 5. Social Security Number<br>214-22-1098  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>80 Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.  |
|  | 8. Date of Birth (Month, Day, Year)<br>July 11, 1916  |  | 9. Birthplace (State or Foreign Country)<br>Maryland  |                                |   |
| To Be Completed by Funeral Director                                  | Usual Residence of Decedent   |  |   |                                |   |
|  | 10a. State<br>Maryland  | 10b. County<br>Wicomico  | 10c. City, Town or Location<br>Salisbury  |                                | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
|  | 10e. Street and Number<br>105 Times Square  |  | 10f. Zip Code<br>21801  |                                | 10g. Citizen of What Country?<br>USA  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0                               |                                |   |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Housewife  |  | 16b. Kind of Business/Industry<br>Domestic  |                                |   |
|  | 17. Father's Name (First, Middle, Last)<br>Frederick George Discher   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>George Ethel Haddaway  |                                |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Ronald E. Small/son   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>P.O. Box 914, Severna Park, MD 21146                 |                                |   |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Parkwood Cemetery   |                                | 20c. Location - City or Town, State<br>8/9/96 Baltimore, MD   |
|  | 21. Signature of Funeral Service Licensee<br>David Thompson MO1051  |  | 22. Name and Address of Facility<br>Holloway Funeral Home<br>501 Snow Hill Rd., Salisbury, MD 21804   |                                |   |
| Physician<br>/Medical<br>Examiner                                    | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. PNEUMONIA.<br>Due to (or as a consequence of):<br>b. CONGESTIVE HEART FAILURE<br>Due to (or as a consequence of):<br>c. AC RENAL FAILURE<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |                                | Approximate Interval Between Onset and Death<br>7 Days.<br>7 Days.<br>1 Days  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DM.<br>Atherosclerotic cardiovascular disease   |  |   |                                | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |                                | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |                                | 28b. Time of Injury<br>M  |
|  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred   |                                |   |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                |   |
|  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |                                |   |
| State Registrar  | 29b. Signature and title of certifier<br>Maurice Lipp MD  |  | 29c. License number<br>D32014   |                                | 29d. Date signed (Month, Day, Year)<br>8/7/96   |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>MATTHEW MOONCH 547-E RIVERSIDE PARK SALISBURY MD 21801  |  |   |                                |   |
| 31. Date filed (Month, Day, Year)<br>AUG 08 1996                     |   |  |   |                                |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



96 25879

## Reg. No.

**Division of Vital Records, P.O. Box 68760,**

Handwritten text, likely bleed-through from the reverse side of the page. The text is mostly illegible due to fading and bleed-through.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25880

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Milo F. Turner

2. Date of Death

August 07 1996

3. Time of Death

9:20 AM

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital Center

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

5. Social Security Number

577-60-4802

8. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

82

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

July 13, 1914

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Temple Hills

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2505 St. Clair Drive

10f. Zip Code

20748

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

Private Industry

17. Father's Name (First, Middle, Last)

Howard A. Turner

18. Mother's Name (First, Middle, Maiden Surname)

Ellenor Diehl

19a. Informant's Name/Relationship (Type, Print)

Larry Turner

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 802, Charlottesville, Virginia 22902

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Schellsburg Cemetery

Date

8/10/96

20c. Location - City or Town, State

Schellsburg, PA

21. Signature of Funeral Service Licensee

Henry S. Ford

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.

4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute myocardial infarction  
Due to (or as a consequence of):b. A.S.H.D.  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

9:18 AM

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

N/A

28b. Time of Injury

N/A-M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

N/A

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Abdul H. Fadul MD

29c. License number

D15765

29d. Date signed (Month, Day, Year)

8-7-1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Abdul H. Fadul, MD - 6228 Oxon Hill Rd Oxon Hill MD 20745

31. Date filed (Month, Day, Year)

AUG 08 1996

32. Registrar's Signature

John H. Harkins

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



96-4384-033

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEMS: 23 PART I, 27, 28a-f, PER ME State of Maryland / Department of Health and Mental Hygiene  
FILM G-738 8/29/96 t.t

## Certificate of Death

Reg. No.

96 25881

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitPhysician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |  |   |  |   |
|---|--|--|---|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>JAMES A. TOWNSEND</b>  |  | 2. Date of Death<br>Month Day Year<br><b>AUGUST 4 1996</b>   |   | 3. Time of Death<br><b>2:30 P.M.</b>   |   |
| 4a. Facility Name (If not institution, give street and number)<br><b>6170 OXON HILL ROAD</b>  |  |  | 4b. City, Town, or Location of Death<br><b>OXON HILL</b>  |  | 4c. County of Death<br><b>PRINCE GEORGES</b>          |
| 5. Social Security Number<br><b>247-70-6193</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>52</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 9, 1943</b>   | 9. Birthplace (State or Foreign Country)<br><b>Marion, S.C.</b>  |   |
| Usual Residence of Decedent   |  |  |   |  |   |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Prince George's</b>  |   | 10c. City, Town or Location<br><b>Temple Hills</b>   |   |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |   |  |   |
| 10e. Street and Number<br><b>1906 Colebrook Drive</b>   |  |  | 10f. Zip Code<br><b>20748</b>   |  | 10g. Citizen of What Country?<br><b>United States</b> |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify:<br><b>African American</b>   |  |  |   |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Retired MPD Officer</b>  |   | 16b. Kind of Business/Industry<br><b>Government</b>  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Henry Adams</b>   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Bettie Mae Evans</b>  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Sheary Townsend - Wife</b>   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2034 South Anvil Lane, Temple Hills, MD 20748</b> |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Olivet Cemetery</b>   |   | 20c. Location - City or Town, State<br><b>Washington, D.C.</b>   |   |
| 21. Signature of Funeral Service Licensee<br><b>John T. Stewart III</b>   |  | 22. Name and Address of Facility<br><b>STEWART FUNERAL HOME, Inc.<br/>4001 Benning Road, N. E., Washington, D. C.</b>  |   |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |   |  |   |
| Immediate Cause (Final disease or condition resulting in death)   |  |  |   |  |   |
| a. <b>CONTACT GUNSHOT WOUND OF CHEST</b>  |  |  |   |  |   |
| Due to (or as a consequence of):  |  |  |   |  |   |
| b. Due to (or as a consequence of):   |  |  |   |  |   |
| c. Due to (or as a consequence of):   |  |  |   |  |   |
| d. Due to (or as a consequence of):   |  |  |   |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   |  |   |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |   |  |   |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |   |  |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |   |  |   |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>MOTEL</b> |   |  |   |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28e. Date of Injury (Month, Day, Year)<br><b>FOUND 8/4/96</b>  |   | 28f. Time of Injury (Month, Day, Year)<br><b>FOUND 12:30 M</b>   |   |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred<br><b>SUBJECT SHOT SELF</b>  |   |  |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>FOUND IN MOTEL ROOM</b>  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>6170 OXON HILL ROAD<br/>PRINCE GEORGE'S COUNTY</b>  |   |  |   |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |  |   |
| 29b. Signature and title of certifier<br><b>Blayne McNeill</b>  |  | 29c. License number<br><b>O.C.M.E.</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>AUGUST 5, 1996</b>   |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Harold A. Koser and 111 Penn Street, Baltimore, Maryland 21201</b>   |  |  |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>AUG 06 1996</b>   |  | 32. Registrar's Signature<br><b>John Andrew Randall</b>  |   |  |   |

State  
Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25882

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Mary Edna Thomas

2. Date of Death

Month

Day

Year

Aug

5

96

3. Time of Death

1505

4a. Facility Name (If not institution, give street and number)

8018 Crain Highway

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

AA

5. Social Security Number

217-36-7908

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

57 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

06-30-39

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8018 Crain Highway

10f. Zip Code

21061

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Driver

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Herman Newman

18. Mother's Name (First, Middle, Maiden Surname)

Lena Butler

19a. Informant's Name/Relationship (Type, Print)

Charles Thomas/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1243 Old Dorsey Road, Harmans, Maryland 21077

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resurrection Cemetery

Date

8/9/96

20c. Location - City or Town, State

Clinton, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

J. B. Jenkins Funeral Home

7474 Landover Road, Landover, MD 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Heart Disease UNK

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28e. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 06054

29d. Date signed (Month, Day, Year)

8/5/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William P. Jones, MD 695 America 21035

31. Date filed (Month, Day, Year)

AUG 09 1996

32. Registrar's Signature

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25883

## Certificate of Death

Reg. No.

|   |  |  |  |                                 |   |
|---|--|--|--|---------------------------------|---|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>OLIVER OSWALD THOMAS</b>  |  | 2. Date of Death<br>Month <b>August</b> Day <b>10</b> Year <b>1996</b>   |                                 | 3. Time of Death<br><b>1440</b>   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>PENINSULA REGIONAL MEDICAL CENTER</b>   |  | 4b. City, Town, or Location of Death<br><b>SALISBURY</b>   |                                 | 4c. County of Death<br><b>WICOMICO</b>  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>196-01-6054</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  |
|   | 8. Date of Birth (Month, Day, Year)<br><b>09/24/1911</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>WALES</b>   |                                 |   |
| To Be Completed by Funeral Director           | Usual Residence of Decedent  |  |  |                                 |   |
|   | 10a. State<br><b>MARYLAND</b>  | 10b. County<br><b>SOMERSET</b>   | 10c. City, Town or Location<br><b>PRINCESS ANNE</b>  |                                 | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |
|   | 10e. Street and Number<br><b>12071 S. COLLEGE PLACE</b>  |  | 10f. Zip Code<br><b>21853</b>  |                                 | 10g. Citizen of What Country?<br><b>U.S.</b>  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |                                 | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |                                 |   |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>MANAGER</b>  |  | 16b. Kind of Business/Industry<br><b>FOOD STORES</b>   |                                 |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>ISAAC JAMES THOMAS</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ELIZABETH SAUNDERS</b>   |                                 |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>ROBERT THOMAS</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>92 EASTWINDS COURT, PALM HARBOR, FLORIDA 34683</b>   |                                 |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MANOKIN PRESBYTERIAN CEMETERY</b>   |                                 | 20c. Location - City or Town, State<br><b>PRINCESS ANNE, MD.</b>  |
|   | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i> <b>M00295</b>  |  | 22. Name and Address of Facility<br><b>HINMAN FUNERAL HOME</b><br><b>11673 SOMERSET AVE., PRINCESS ANNE, MD. 21853</b>   |                                 |   |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. <i>INTestinal Perforation</i></b><br>Due to (or as a consequence of):<br><b>b. <i>Probable Bacterial Peritonitis</i></b><br>Due to (or as a consequence of):<br><b>c. <i>(GERD bleed 2° to Above)</i></b><br>Due to (or as a consequence of):<br><b>d.</b> |  |  |                                 | Approximate Interval Between Onset and Death<br><b><i>one day</i></b>   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.<br><b><i>END STAGE COPD, Steroid Dependent</i></b><br><b><i>DVT + Pulmonary Embolus on Counselin</i></b><br><b><i>CASE MINOR'S Lung</i></b>   |  |  |                                 | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |                                 | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |                                 | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicida <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)   | 28b. Time of Injury<br><b>M</b> | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|   | 28d. Describe how injury occurred  |  | 28e. Piece of injury - At home, farm, street, factory, office building, etc. (Specify)   |                                 |   |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                 |   |
|   | 29b. Signature and title of certifier<br><i>[Signature]</i>  |  | 29c. License number<br><b>D39813</b>   |                                 | 29d. Date signed (Month, Day, Year)<br><b>8/14/96</b>   |
| State Registrar                               | 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br><b>MARTINS 1104 Henshaw Drive Salisbury MD 21801</b>   |  |  |                                 |   |
|   | 31. Date filed (Month, Day, Year)<br><b>AUG 12 1996</b>  |  | 32. Registrar's Signature<br><i>[Signature]</i>  |                                 |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



96-4698-033

ITEMS: 23 PART I, II, 27, PER

MEO FILM G-738 8/30/96 t.t.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 25884

Reg. No.

|   |   |  |   |   |  |
|---|---|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ONESIMUS</b>   |  | 2. Date of Death<br>Month <b>AUGUST</b> Day <b>19</b> Year <b>1996</b>  |   | 3. Time of Death<br><b>10:00A.M.</b>   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>6605 LIVINGSTON ROAD</b>   |  | 4b. City, Town, or Location of Death<br><b>OXON HILL</b>  |   | 4c. County of Death<br><b>PRINCE GEORGES</b>   |
| Funeral<br>Director   | 5. Social Security Number<br><b>436-38-7038</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>64</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>JAN 18 1932</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Louisiana</b>  |  |   |   |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |  | 10c. City, Town or Location<br><b>Clinton</b>   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
|   | 10e. State<br><b>Maryland</b>   | 10b. County<br><b>Prince George's</b>                                      |   |   |  |
|   | 10e. Street and Number<br><b>6809 Killarney Street</b>  |  | 10f. Zip Code<br><b>20735</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>Korean</b> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |   |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4+</b>  |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Electrical Engineer</b>                          |   | 16b. Kind of Business/Industry<br><b>US Government</b>   |
|   | 17. Father's Name (First, Middle, Last)<br><b>Dee Venzant</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Melinda Rushing Venzant</b>   |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Martha G. Venzant (Ex-wife)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6809 Killarney Street Clinton, MD 20735</b>                 |   |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Simmons Funeral Home</b>   |   | 20c. Location - City or Town, State<br><b>8-26-96 Jonesboro, Louisiana</b>   |
|   | 21. Signature of Funeral Service Licensee<br> <b>M00173</b>   |  | 22. Name and Address of Facility<br><b>J.H. Eberwein Mortuary</b><br><b>4433 White Pls La White Pls., MD 20695</b>  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>SEIZURE DISORDER</b><br>Due to (or as a consequence of):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>CHRONIC ALCOHOLISM</b><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |   |  |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CHRONIC ALCOHOLISM</b>   |   |  |   |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |   |   |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |   |   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |   |   |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SHED</b>   |   |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   |  |   |   |  |
| 28a. Date of Injury (Month, Day Year)<br><b>28b. Time of Injury</b><br><b>M</b><br><b>28c. Injury at Work?</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><b>28d. Describe how injury occurred</b><br><b>28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)</b><br><b>28f. Location (Street and Number or Rural Route Number, City or Town, State)</b>   |   |  |   |   |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |  |   |   |  |
| 29b. Signature and title of certifier<br><br><b>Dennis J. Chute MD</b>   |   |  |   |   |  |
| 29c. License number<br><b>O.C.M.E.</b>  |   |  |   |   |  |
| 29d. Date signed (Month, Day, Year)<br><b>AUGUST 20, 1996</b>   |   |  |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201</b>  |   |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 26 1996</b>   |   |  |   |   |  |
| 32. Registrar's Signature<br><br><b>John A. Randall</b>  |   |  |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25885

## Certificate of Death

Reg. No.

|  |  |   |   |  |   |   |  |  |  |
|--|--|---|---|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Mabel Lillian Voorhees</b>  |   |   |  | 2. Date of Death<br>Month <b>08</b> Day <b>12</b> Year <b>1996</b>  |   | 3. Time of Death<br><b>0105 AM</b>   |  |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>Anne Arundel Medical Center</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>Annapolis</b>  |   | 4c. County of Death<br><b>Anne Arundel</b>   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>056-01-4443</b>  |   | 8. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>93</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>Jan/18/1903</b>                                      | 9. Birthplace (State or Foreign Country)<br><b>New York</b>  |  |
|  | Usual Residence of Decedent  |   |   |  |   |   |  |  |  |
| To Be Completed by Funeral Director  | 10e. State<br><b>MD</b>  |   | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Annapolis</b>   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
|  | 10e. Street and Number<br><b>3921 River Club Road</b>  |   |   |  | 10f. Zip Code<br><b>21037</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |   | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>AT&amp;T Employee</b>             |  | 16b. Kind of Business/Industry<br><b>Telephone Industry</b>   |   |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Henry Veghte Voorhees</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Hattie Lane</b>   |   |  |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>James Voorhees (nephew)</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3921 River Club Rd/Edgewater MD 21037</b>   |   |  |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   |  | Date<br><b>8/13</b>   |   | 20c. Location - City or Town, State<br><b>Alexandria VA</b>                                    |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Melanie Wilhelm-Hogener</i>  |   |   |  | 22. Name and Address of Facility<br><b>Advent Funeral &amp; Cremation Services<br/>Annapolis MD 21401</b>   |   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>Cachexia of malignancy.</b><br>Due to (or as a consequence of):<br>b. <b>metastasis liver</b><br>Due to (or as a consequence of):<br>c. <b>Carcinoma left lung.</b><br>Due to (or as a consequence of):<br>d.<br><br>Approximate Interval Between Onset and Death<br><b>2 months + year + year</b> |   |   |  |   |   |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diarrhea</b>  |   |   |  |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |   |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M                         |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><i>George C. Sammons</i>   |   | 29c. License number<br><b>108314</b>             |   | 29d. Date signed (Month, Day, Year)<br><b>8/12/96</b>                                       |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>George C. Sammons 205 Ridgely Ave Annapolis, Maryland</b>   |  |   |   |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 15 1996</b>  |  | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>  |   |  |   |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





96 25886

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>William White</i>   |  |  |  | 2. DATE OF DEATH<br>MONTH <i>July</i> DAY <i>31</i> YEAR <i>96</i>  |  | 3. TIME OF DEATH<br><i>11:46 PM</i>   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>579-36-5836</i>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>67</i> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>7/16/29</i>  |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br><i>Washington Adventist Hospital</i>   |  |  |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><i>takoma Park</i>   |  | 8c. COUNTY OF DEATH<br><i>Montgomery</i>  |  |
| 9a. RESIDENCE OF DECEDENT  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH   |  |   |  |
| 10a. STATE<br><i>Md.</i>   |  | 10b. COUNTY<br><i>Prince George's</i>  |  | 10c. CITY, TOWN OR LOCATION<br><i>Takoma Park</i>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><i>6720 Conway Avenue</i>  |  |  |  | 10f. ZIP CODE<br><i>20912</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>Black</i>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><i>Elementary/Secondary (0-12)</i> <i>College (1-4 or 5 +)</i><br><i>12th</i>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Night Stocker</i>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Giant Food Stores</i>                                      |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Albert White</i>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Florence Gorham</i>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Nannie B. White-Wife</i>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>Same as #10 above</i>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Harmony Mem. Park 8/7/96</i>   |  | 20c. LOCATION — City or Town, State<br><i>Landover, Md.</i>   |  | 20d. DATE<br><i>8/7/96</i>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Darryl H. Pratt</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>H.S. Washington &amp; Sons, Inc.<br/>4925 Burroughs Ave., N.E.</i>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>acute myocardial infarction</i><br>Approximate interval Between Onset and Death <i>45 min</i><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><i>M</i>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John Tander MD</i>   |  |  |  | 29c. LICENSE NUMBER<br><i>D08546</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>August 1 96</i>                                       |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>John Tander 8218 Wisconsin Ave Bethesda MD</i>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>AUG 08 1996</i>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Andrew Raskett</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25887

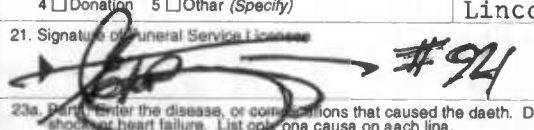
Amended Part 1, 27, P.G.C. 8/13/96 CR

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

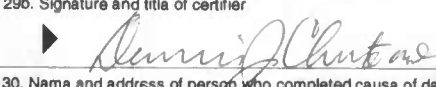
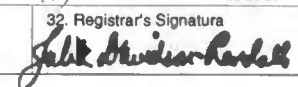
To Be Completed by Funeral Director

|   |  |  |                                |  |   |
|---|--|--|--------------------------------|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>GEORGE PERCY WHEELER</b>   |  | 2. Date of Death<br>Month <b>JULY</b> Day <b>27</b> Year <b>1996</b>   |                                | 3. Time of Death<br><b>2127PM</b>  |   |
| 4a. Facility Name (If not institution, give street and number)<br><b>ANDREWS AIR FORCE BASE HOSPITAL</b>  |  | 4b. City, Town, or Location of Death<br><b>CAMP SPRINGS</b>  |                                | 4c. County of Death<br><b>PRINCE GEORGES</b>   |   |
| 5. Social Security Number<br><b>233-38-6034</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>68</b> Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 24, 1928</b> |
| 9. Birthplace (State or Foreign Country)<br><b>Bownemont, W.VA</b>  |  |  |                                |  |   |
| Usual Residence of Decedent   |  | 10a. State<br><b>Maryland</b>  |                                |  |   |
| 10b. County<br><b>Prince George's</b>   |  | 10c. City, Town or Location<br><b>Forestville</b>  |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |
| 10e. Street and Number<br><b>3011 Logan Street</b>  |  | 10f. Zip Code<br><b>20747</b>  |                                | 10g. Citizen of What Country?<br><b>United States</b>  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:      |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+</b> College (1-4or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Director of Logistics &amp; Supply</b> |                                | 16b. Kind of Business/Industry<br><b>Retired USAF and D. C. Public Schools</b>   |   |
| 17. Father's Name (First, Middle, Last)<br><b>Unknown</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Evelyn M. Wheeler</b>  |                                |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Willie R. Wheeler - Wife</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3011 Logan Street, Forestville, Maryland 20747</b> |                                |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lincoln Memorial Cemetery</b>   |                                | 20c. Location - City or Town, State<br><b>8/3/96 Suitland, Maryland</b>  |   |
| 21. Signature of Funeral Service Licensee<br> <b>#94</b>  |  | 22. Name and Address of Facility<br><b>JORDAN FUNERAL SERVICE</b><br><b>4001 Benning Road, N. E., Washington, D. C.</b>                                |                                |  |   |

|   |  |  |  |
|---|--|--|--|
| 23a. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Atherosclerotic cardiovascular disease</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Atherosclerotic cardiovascular disease</b><br>Due to (or as a consequence of):<br><br><b>Atherosclerotic cardiovascular disease</b><br>Due to (or as a consequence of):<br><br><b>Atherosclerotic cardiovascular disease</b><br>Due to (or as a consequence of): |  | Approximate Interval Between Onset and Death |  |
|---|--|--|--|

|  |  |  |  |
|--|--|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|  |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |
|  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>  |  |
|   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |

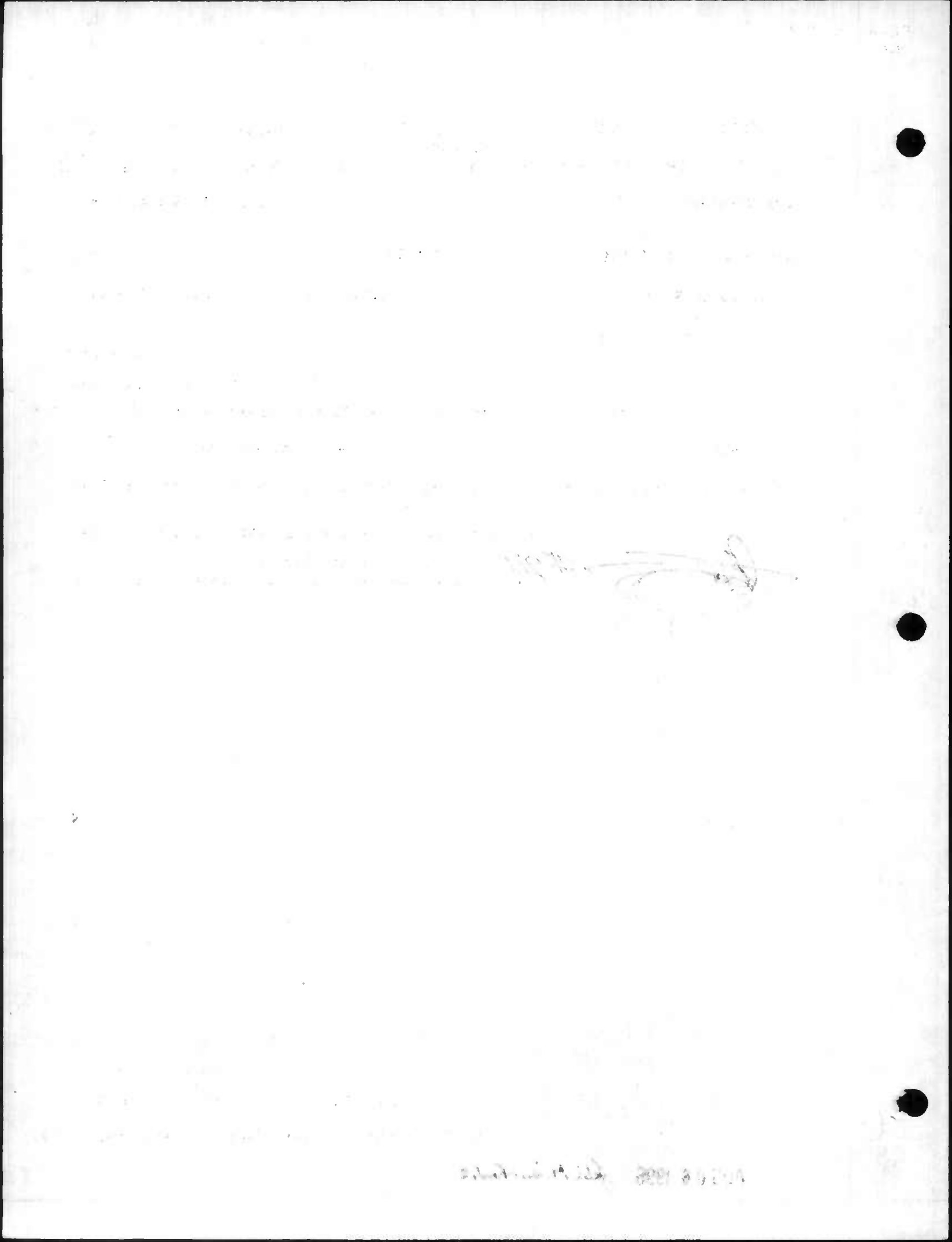
|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><br><b>Dennis J. Chute MD</b> |  | 29c. License number<br><b>O.C.M.E.</b> |  |
|  |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 28, 1996</b>   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201</b>   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 06 1996</b>  |  | 32. Registrar's Signature<br>  |  |  |  |

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.



96 25888

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CASSIE WRIGHT</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>JULY</b> DAY <b>30</b> , YEAR <b>1996</b>   |  | 3. TIME OF DEATH<br><b>9:00 P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>578-34-1461</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>83</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>3-25-1913</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>FORT MOTTE, SC</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>1103 GLEN WILLOW DR., #12</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>CAPITOL HEIGHTS</b>  |  |
| 9c. COUNTY OF DEATH<br><b>PRINCE GEORGES</b>   |  |  |  | 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>PRINCE GEORGES</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>CAPITOL HEIGHTS</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>1103 GLEN WILLOW DRIVE, #12</b>   |  |
| 10f. ZIP CODE<br><b>20743</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+) <b>CAFETERIA MANAGER</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>CAFETERIA MANAGER</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>N/A</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>ANDERSON</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>LIZIE TAYLOR</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>ROSE WRIGHT</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1103 GLEN WILLOW DR., #12 CAPITOL HEIGHTS, MD 20743</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>HARMONY MEMORIAL PARK 5-96</b>   |  | 20c. LOCATION — City or Town, State<br><b>LANDOVER, MD</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>B. C. Taylor</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>TAYLOR'S FUNERAL HOME<br/>1722 NORTH CAPITOL ST., NW WASH. DC</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiopulmonary Arrest</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Metastatic Breast Cancer</b> |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>W. B. Baidas</i> M.D.  |  |  |  | 29c. LICENSE NUMBER<br><b>D 41373</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/1/96</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>SAID M. BAIDAS, MD-3800 RESERVOIR ROAD, NW WASHINGTON, DC 20007</b>  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 6 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25889

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ELMER LEE WILCHER

2. Date of Death

Month

Day

Year

July

28, 1996

3. Time of Death

12:27 pm

4e. Facility Name (If not institution, give street and number)

WASHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

252-82-7157

6. Sex

M 20 F

7. Age (In yrs. last birthday)

46

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Dec. 4, 1949

9. Birthplace (State or Foreign Country)

Sparta, GA

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Adelphi

10d. Inside City Limits

Yes 2 No

10e. Street and Number

7909 Kreeger Drive, Apt. 110

10f. Zip Code

20783

10g. Citizen of What Country?

United States

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify:  
African American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Warehouseman

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Jewell Wilcher, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Annie B. King Wilcher

19e. Informant's Name/Relationship (Type, Print)

Annie B. Wilcher - Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7909 Kreeger Drive, #110, Adelphi, MD 20783

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ft. Lincoln Cemetery

Date

8/2/96

20c. Location - City or Town, State

Brentwood, MD

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

STEWART FUNERAL HOME, Inc.

4001 Benning Road, N.E., Washington, D.C.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Sepsis  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Liver Failure  
Due to (or as a consequence of):

one week

c. Cirrhosis of Liver  
Due to (or as a consequence of):

years

d. Alcoholism  
Due to (or as a consequence of):

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

X

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John T. Stewart III, M.D.

29c. License number

D46093

29d. Date signed (Month, Day, Year)

July 28, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert M. Stogdun 7305 Hanover Parkway Greenbelt, MD 20770

31. Date filed (Month, Day, Year)

AUG 05 1996

32. Registrar's Signature

John T. Stewart III

State Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25890

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JESSE R WILKINS.

2. Date of Death

Month Day Year  
JULY 30 1996

3. Time of Death

12:16 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

CHURCH HOSPITAL, 101 NORTH BOND STREET

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

5. Social Security Number

241-26-4681

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

12/20/1903

9. Birthplace (State or Foreign Country)

NORTH CAROLINA

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

201 NORTH BROADWAY ST

10f. Zip Code

21231

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
11TH GRADECollege (1-4or 5+)  
NONE

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SHORT ORDER COOK

16b. Kind of Business/Industry

RESTAURANT

17. Father's Name (First, Middle, Last)

BUD WILKINS

18. Mother's Name (First, Middle, Maiden Surname)

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

ROY A. WILKINS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1424 W STREET NW #201, WASHINGTON, DC 20009

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WASHINGTON NATIONAL 8/5/95

Data

20c. Location - City or Town, State

Suitland, Md

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

JOHN T. RHINES CO., INC.  
3030 12TH ST NE, DC 20017

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ASPIRATION PNEUMONIA.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

weight loss.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D45186.

29d. Date signed (Month, Day, Year)

July 30th 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nirumala Saray, 100 N Broadway, Church Hospital, Baltimore MD

31. Date filed (Month, Day, Year)

AUG 05 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25891

## Certificate of Death

Reg. No.

|  |   |  |   |  |  |  |  |  |  |  |  |
|--|---|--|---|--|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner      | 1. Decedent's Name (First, Middle, Last)<br><b>JOHN RUSSELL</b>   |  |   |  | 2. Date of Death<br>Month <b>Aug</b> Day <b>8</b> Year <b>1996</b>   |  |  |  | 3. Time of Death<br><b>1830</b>  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>PENINSULA REGIONAL MEDICAL CENTER</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>SALISBURY</b>   |  |  |  | 4c. County of Death<br><b>WICOMICO</b>   |  |  |
| Funeral<br>Director                    | 5. Social Security Number<br><b>051-16-7708</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 24, 1918</b>                      |  | 9. Birthplace (State or Foreign Country)<br><b>New York</b>  |  |  |
|  | 10a. State<br><b>MD.</b>  |  | 10b. County<br><b>Wicomico</b>  |  | 10c. City, Town or Location<br><b>Hebron</b>   |  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
| To Be Completed by Funeral Director    | 10e. Street and Number<br><b>27168 N. Tourmaline Dr.</b>  |  |   |  | 10f. Zip Code<br><b>21830</b>  |  |  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>WW II</b><br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Engineer</b>   |  |  |  | 16b. Kind of Business/Industry<br><b>Broadcasting</b>  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>John D. Whittaker</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ethel Keenan</b>   |  |  |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Lois T. Whittaker</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>27168 N. Tourmaline Dr. Hebron, Md. 21830</b>  |  |  |  |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Kensico Cemetery</b>   |  | Date<br><b>8/12</b>  |  | 20c. Location - City or Town, State<br><b>ValHalla, N. Y.</b>                    |  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |  |   |  | 22. Name and Address of Facility<br><b>Bounds Funeral Home</b><br><b>705 E. Main St., Salisbury, Md. 21804</b>   |  |  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |  |  |  |  |  |  | Approximate Interval Between Onset and Death |
|  | Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Spoosis</i><br>Due to (or as a consequence of):  |  |   |  |  |  |  |  |  |  | <i>1d</i>                                    |
|  | Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. <i>Pneumonia</i><br>Due to (or as a consequence of):  |  |   |  |  |  |  |  |  |  | <i>1wk</i>                                   |
| c.<br>Due to (or as a consequence of): |   |  |   |  |  |  |  |  |  |  |  |
| d.<br>Due to (or as a consequence of): |   |  |   |  |  |  |  |  |  |  |  |
| Physician<br>/Medical<br>Examiner      | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Renal failure</i><br><i>Parkinson's Disease</i>  |  |   |  |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |
|  |   |  |   |  |  |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
|  |   |  |   |  |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |  |  |
|  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |  |
|  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)     |  |  |  |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |  |  |  |  |  |  |  |
|  | 29b. Signature and title of certifier<br><i>[Signature]</i>   |  |   |  | 29c. License number<br><b>D47619</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>8/8/96</b>                             |  |  |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>OSCAR GUALTEROS MD. 262 Tighman Rd. Salisbury MD 21804</b>   |  |   |  |  |  |  |  |  |  |  |
|  | 31. Date filed (Month, Day, Year)<br><b>AUG 09 1996</b>   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25892

|                                     |   |  |   |                                |  |
|-------------------------------------|---|--|---|--------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Sherman Eugene</b>   |  | 2. Date of Death<br>Month <b>WINDER</b> Day <b>August</b> Year <b>12, 1996</b>  |                                | 3. Time of Death<br><b>0110</b>  |
|                                     | 4a. Facility Name (If not institution, give street and number)<br><b>PENINSULA REGIONAL MEDICAL CENTER</b>  |  | 4b. City, Town, or Location of Death<br><b>SALISBURY</b>  |                                | 4c. County of Death<br><b>WICOMICO</b>   |
| Funeral<br>Director                 | 5. Social Security Number<br><b>213-70-7699</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>39</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|                                     | 8. Date of Birth (Month, Day, Year)<br><b>Apr. 30 1957</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |                                |  |
| To Be Completed by Funeral Director | Usual Residence of Decedent   |  | 10a. State<br><b>Maryland</b>   |                                | 10b. County<br><b>Wicomico</b>   |
|                                     | 10c. City, Town or Location<br><b>Salisbury</b>   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |                                |  |
|                                     | 10e. Street and Number<br><b>1532 Duke Drive</b>  |  | 10f. Zip Code<br><b>21801</b>   |                                | 10g. Citizen of What Country?<br><b>U.S.A</b>  |
|                                     | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |
|                                     | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |                                |  |
|                                     | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Laborer</b>   |  | 16b. Kind of Business/Industry<br><b>None</b>   |                                |  |
|                                     | 17. Father's Name (First, Middle, Last)<br><b>William Long</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Nola Lawrence</b>   |                                |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br><b>Nola Sturgis</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>25158 Nanticoke Rd. Quantico Md. 21856</b>  |                                |  |
|                                     | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Quantico</b>   |                                | 20c. Location - City or Town, State<br><b>Quantico, Md.</b>  |
|                                     | 21. Signature of Funeral Service Licensee<br><b>Gladys B. Stewart</b>   |  | 22. Name and Address of Facility<br><b>Stewart Funeral Home<br/>821 West Rd. Salisbury, Md. 21801</b>   |                                |  |
| Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>a. <b>Chemotherapy induced neutropenic</b><br>Due to (or as a consequence of):<br>b. <b>Sepsis (Streptococcus Viridans)</b><br>Due to (or as a consequence of):<br>c. <b>Squamous Cell Ca Larynx</b><br>Due to (or as a consequence of):<br>d. |  |   |                                | Approximate Interval Between Onset and Death   |
|                                     | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |                                | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
|                                     | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
|                                     | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                |  |
|                                     | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |                                | 28b. Time of Injury<br><b>M</b>  |
|                                     | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred   |                                |  |
|                                     | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                |  |
|                                     | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |                                |  |
|                                     | 29b. Signature and Title of certifier<br><b>Eugene Sherman</b>  |  | 29c. License number<br><b>D 20507</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>8/12/96</b>  |
|                                     | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Joseph W. GRASSO 145 E. CARROLL ST SALISBURY MD</b>  |  |   |                                |  |
| State<br>Registrar                  | 31. Date filed (Month, Day, Year)<br><b>AUG 13 1996</b>   |  | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>  |                                |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the paper is devoted to the study of the properties of the function  $f(x)$  defined by the equation

$$f(x) = \int_0^x \frac{1}{1+t^2} dt$$

It is shown that the function  $f(x)$  is continuous and differentiable on the interval  $(-\infty, \infty)$  and that its derivative is given by the formula

$$f'(x) = \frac{1}{1+x^2}$$

Furthermore, it is proved that the function  $f(x)$  is bounded on the interval  $(-\infty, \infty)$  and that its range is the interval  $(0, \pi/2)$ .

2. In the second part of the paper, we consider the function  $g(x)$  defined by the equation

$$g(x) = \int_0^x \frac{t}{1+t^2} dt$$

It is shown that the function  $g(x)$  is continuous and differentiable on the interval  $(-\infty, \infty)$  and that its derivative is given by the formula

$$g'(x) = \frac{x}{1+x^2}$$

Furthermore, it is proved that the function  $g(x)$  is bounded on the interval  $(-\infty, \infty)$  and that its range is the interval  $(-\pi/4, \pi/4)$ .

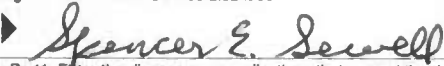

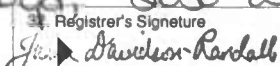
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25893

## Certificate of Death

Reg. No.

|   |   |   |  |  |  |
|---|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Robert Wilson</b>                              |   | 2. Date of Death<br>Month <b>August</b> Day <b>16</b> Year <b>1996</b> |  | 3. Time of Death<br><b>3:25 P.M.</b>             |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Bayside Nursing Home</b> |   | 4b. City, Town, or Location of Death<br><b>Lexington Park</b>          |  | 4c. County of Death<br><b>St. Marys</b>          |
| Funeral<br>Director   | 5. Social Security Number<br><b>215-34-3095</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>59</b> Yrs.                       | If Under 1 Year<br>Months <b>0</b> Days <b>0</b>   | If Under 24 Hrs.<br>Hours <b>0</b> Min. <b>0</b> |
|   | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 10, 1936</b>                                   |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>            |  |  |
| Usual Residence of Decedent   |   |   |  |  |  |
| 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Calvert</b>   |  | 10c. City, Town or Location<br><b>Port Republic</b>  |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |  |  |
| 10e. Street and Number<br><b>5427 Broomes Island Road</b>   |   | 10f. Zip Code<br><b>20676</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |   |   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Farmer</b>  |  | 16b. Kind of Business/Industry<br><b>Farming</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Unknown</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Grace Wilson</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Kenneth Gross/Friend</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2004 Barlowe Pl. Palmer Park, MD 20785</b>  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Ernestine Jones Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>8/21/96 Chesapeake Beach, MD</b>   |  |
| 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br><b>Sewell Funeral Home<br/>1451 Dares Beach Rd. Prince Frederick, MD 20678</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)<br><b>Chronic Obstructive Pulmonary disease</b>   |   |   |  |  |  |
| Due to (or as a consequence of):<br><b>anoxic encephalopathy</b>  |   |   |  |  |  |
| Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |   |   |  |  |  |
| Due to (or as a consequence of):  |   |   |  |  |  |
| Due to (or as a consequence of):  |   |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>congestive Heart Failure, Tracheal stenosis</b>  |   |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |   |   |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred   |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |  |  |  |
| 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>D19917</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>8/17/96</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. James C. Boyd, 2000 Wildwood Center - California MD 20619</b>  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 21 1996</b>   |   |   |  |  |  |
| 32. Registrar's Signature<br>  |   |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1941  
The first of the year  
was a very dry one  
and the crops were  
very poor.

The second of the year  
was a very wet one  
and the crops were  
very good.

The third of the year  
was a very dry one  
and the crops were  
very poor.

The fourth of the year  
was a very wet one  
and the crops were  
very good.

The fifth of the year  
was a very dry one  
and the crops were  
very poor.

The sixth of the year  
was a very wet one  
and the crops were  
very good.

The seventh of the year  
was a very dry one  
and the crops were  
very poor.

The eighth of the year  
was a very wet one  
and the crops were  
very good.



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State of Maryland / Department of Health and Mental Hygiene

96 25894

## Certificate of Death

Reg. No.

|   |  |                                       |   |   |  |  |   |  |
|---|--|---------------------------------------|---|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>James William Wallace</b>   |                                       |   |   | 2. Date of Death<br>Month <b>August</b> Day <b>12</b> Year <b>1996</b>   |  | 3. Time of Death<br><b>1423</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number).<br><b>Calvert Memorial Hospital</b>  |                                       |   |   | 4b. City, Town, or Location of Death<br><b>Prince Frederick</b>  |  | 4c. County of Death<br><b>Calvert</b>                                   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-12-3155</b>  |                                       | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>April 20, 1919</b>            |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |                                       |   |   |  |  |   |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent  |                                       |   |   |  |  |   |  |
|   | 10a. State<br><b>Maryland</b>  |                                       | 10b. County<br><b>Calvert</b>   |   | 10c. City, Town or Location<br><b>Huntingtown</b>  |  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
|   | 10e. Street and Number<br><b>4690 Solomons Island Road</b>   |                                       |   |   | 10f. Zip Code<br><b>20639</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                             |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |                                       | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)  |                                       |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Farmer</b>   |  | 16b. Kind of Business/Industry<br><b>Farming</b>                        |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Julius Wallace</b>   |                                       |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Liona Reed</b>   |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Alvin Wallace/Son</b>   |                                       |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6295 Broomes Island Rd. St. Leonard, MD 20685</b>  |  |   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |                                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Patuxent UM Church Cem.</b>  |   | Date<br><b>8/16/96</b>   |  | 20c. Location - City or Town, State<br><b>Huntingtown, MD</b>           |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Spencer E. Lawrence</i>  |                                       |   |   | 22. Name and Address of Facility<br><b>Sewell Funeral Home<br/>1451 Dares Beach Rd. Prince Frederick, MD 20678</b>   |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. Ventricular Fibrillation</b><br>Due to (or as a consequence of):<br><b>b. Coronary artery disease</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |                                       |   |   |  |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |                                       |   |   |  |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |                                       |   |   |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |                                       |   |   |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |                                       |   |   |  |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |                                       |   |   |  |  |   |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |                                       |   |   |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year) |   | 28b. Time of injury<br><b>M</b>                         |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |                                       |   | 28d. Describe how Injury occurred                       |  |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |                                       |   |   |  |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |                                       |   |   |  |  |   |  |
| 29b. Signature and title of certifier<br><i>M. Mathur MD</i>  |  |                                       |   | 29c. License number<br><b>D-25435-</b>                  |  | 29d. Date signed (Month, Day, Year)<br><b>8/14/96</b>                                |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. M. Mathur, Prince Frederick, MD 20678</b>  |  |                                       |   |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 16 1996</b>   |  |                                       |   | 32. Registrar's Signature<br><i>J. Davidson-Randall</i> |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

6

1. The first part of the paper is devoted to the study of the properties of the function  $f(x)$  defined by the equation  $f(x) = \int_0^x f(t) dt$ . It is shown that  $f(x)$  is a constant function.

2. In the second part, we consider the function  $g(x)$  defined by the equation  $g(x) = \int_0^x g(t) dt$ . It is shown that  $g(x)$  is a constant function.

3. In the third part, we consider the function  $h(x)$  defined by the equation  $h(x) = \int_0^x h(t) dt$ . It is shown that  $h(x)$  is a constant function.

4. In the fourth part, we consider the function  $k(x)$  defined by the equation  $k(x) = \int_0^x k(t) dt$ . It is shown that  $k(x)$  is a constant function.

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State of Maryland / Department of Health and Mental Hygiene

96 25895

## Certificate of Death

Reg. No.

|  |  |   |   |  |   |  |   |  |
|--|--|---|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>BEATRICE H. WHYE</b>  |   |   |  | 2. Date of Death<br>Month Day Year<br><b>AUG. 15 1996</b>   |  | 3. Time of Death<br><b>1:45 am</b>                                      |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>ANNAPOLIS CONVALESCENT &amp; REHABILITATION</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>ANNAPOLIS</b>  |  | 4c. County of Death<br><b>ANNE ARUNDEL</b>                              |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-34-8354</b>  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>91</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>SEPT. 29 1904</b>             |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |   | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>ANNE ARUNDEL</b>  |  | 10c. City, Town or Location<br><b>ANNAPOLIS</b>                         |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 10e. Street and Number<br><b>1801 BOWMAN DRIVE</b>  |  | 10f. Zip Code<br><b>21401</b>   |  | 10g. Citizen of What Country?<br><b>US</b>                              |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b> |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5th</b><br>College (1-4 or 5+) <b>0</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>LAUNDREYESS</b>                       |  | 16b. Kind of Business/Industry<br><b>FAIRFIELD NURSING HOME</b>   |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>JOHN STEWART</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ADA LOMAX</b>   |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>RACHEL SMITH (DAUGHTER)</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>20 PAROLE STREET ANNAPOLIS, MD. 21401</b>   |  |   |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ANNAPOLIS MEM. GARDENS</b>   |  | Date<br><b>8/19/96</b>  |  | 20c. Location - City or Town, State<br><b>ANNAPOLIS, MD.</b>            |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Harry D. Reese</b>   |   |   |  | 22. Name and Address of Facility<br><b>WM. REESE &amp; SONS MORTUARY, P.A.<br/>821 WEST ST. ANNAPOLIS, MD. 21401</b>  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Stroke</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   |   |  |   |  |   |  |
|  | Approximate Interval Between Onset and Death<br><b>2 weeks</b>   |   |   |  |   |  |   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cardiomyopathy</b>  |   |   |  |   |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |   |   |  |   |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |   |  |   |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |   |  |   |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |   |  |   |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |
|  |  | 28d. Describe how injury occurred   |   | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |   |  |   |  |
| 29b. Signature and title of certifier<br><b>R. L. Hochman, M.D.</b>  |  | 29c. License number<br><b>DO 5192</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>8/16/96</b>                                  |   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 22a) (Type, Print)<br><b>Richard J. Hochman, MD 1833 A Forest Dr, Annapolis, Md. 21401</b>   |  |   |   |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 16 1996</b>  |  | 32. Registrar's Signature<br><b>John Davidson-Randall</b>   |   |  |   |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25896

|   |  |   |  |  |  |  |   |  |   |    |                                 |  |   |    |  |    |  |    |  |
|---|--|---|--|--|--|--|---|--|---|----|---------------------------------|--|---|----|--|----|--|----|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>LARRY H. WHITE</b>  |   |  |  | 2. Date of Death<br>Month Day Year<br><b>AUG. 13 1996</b>  |  | 3. Time of Death<br><b>0928</b>   |  |   |    |                                 |  |   |    |  |    |  |    |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>ANNE ARUNDEL MEDICAL CENTER</b>   |   |  |  | 4b. City, Town, or Location of Death<br><b>ANNAPOLIS</b>   |  | 4c. County of Death<br><b>ANNE ARUNDEL</b>                              |  |   |    |                                 |  |   |    |  |    |  |    |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>217-40-5828</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>52</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>MAY 19 1944</b>               |  |   |    |                                 |  |   |    |  |    |  |    |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |   | 10a. State<br><b>MARYLAND</b>  |  | 10b. County<br><b>ANNE ARUNDEL</b>   |  | 10c. City, Town or Location<br><b>ANNAPOLIS</b>                         |  |   |    |                                 |  |   |    |  |    |  |    |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 10e. Street and Number<br><b>14 SOUTH MONROE ROAD</b>  |  | 10f. Zip Code<br><b>21402</b>  |  | 10g. Citizen of What Country?<br><b>US</b>                              |  |   |    |                                 |  |   |    |  |    |  |    |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1966-68</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b> |  |   |    |                                 |  |   |    |  |    |  |    |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b>   |   | College (1-4or 5+) <b>0</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>MECHANIC</b>   |  | 16b. Kind of Business/Industry<br><b>SELF EMPLOYED</b>                  |  |   |    |                                 |  |   |    |  |    |  |    |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>VERNON WHITE</b>   |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>PRUDENCE JOHNSON</b>   |  |   |  |   |    |                                 |  |   |    |  |    |  |    |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>LOIS WHITE (WIFE)</b>   |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14 SOUTH MONROE ROAD ANNAPOLIS, MD. 21402</b>  |  |   |  |   |    |                                 |  |   |    |  |    |  |    |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MARYLAND VETERAN CEMETERY</b>   |  | Date<br><b>8/16/96</b>   |  | 20c. Location - City or Town, State<br><b>CROWNSVILLE, MD.</b>          |  |   |    |                                 |  |   |    |  |    |  |    |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Larry H. Reese</i>   |   |  |  | 22. Name and Address of Facility<br><b>WM. REESE &amp; SONS MORTUARY, P.A.<br/>821 WEST ST. ANNAPOLIS, MD. 21401</b>   |  |   |  |   |    |                                 |  |   |    |  |    |  |    |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |  |  |  |  |   |  |   |    |                                 |  |   |    |  |    |  |    |  |
|   | <table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><i>Congestive heart failure</i></td> <td rowspan="4">           Due to (or as a consequence of):<br/><br/>           b. <i>End stage renal disease</i><br/>           Due to (or as a consequence of):<br/><br/>           c. <i>pneumonia</i><br/>           Due to (or as a consequence of):<br/><br/>           d.         </td> <td rowspan="4">           Approximate Interval Between Onset and Death<br/><br/> <b>2 days</b> </td> </tr> <tr><td>b.</td><td></td></tr> <tr><td>c.</td><td></td></tr> <tr><td>d.</td><td></td></tr> </table> |   |  |  |  |  |   |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. | <i>Congestive heart failure</i> | Due to (or as a consequence of):<br><br>b. <i>End stage renal disease</i><br>Due to (or as a consequence of):<br><br>c. <i>pneumonia</i><br>Due to (or as a consequence of):<br><br>d. | Approximate Interval Between Onset and Death<br><br><b>2 days</b> | b. |  | c. |  | d. |  |
|   | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  | a.  | <i>Congestive heart failure</i>  | Due to (or as a consequence of):<br><br>b. <i>End stage renal disease</i><br>Due to (or as a consequence of):<br><br>c. <i>pneumonia</i><br>Due to (or as a consequence of):<br><br>d. | Approximate Interval Between Onset and Death<br><br><b>2 days</b>  |  |   |  |   |    |                                 |  |   |    |  |    |  |    |  |
| b.  |  |   |  |  |  |  |   |  |   |    |                                 |  |   |    |  |    |  |    |  |
| c.  |  |   |  |  |  |  |   |  |   |    |                                 |  |   |    |  |    |  |    |  |
| d.  |  |   |  |  |  |  |   |  |   |    |                                 |  |   |    |  |    |  |    |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>probable lung cancer,</i><br><i>Insulin dependent diabetes</i>   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |  |   |    |                                 |  |   |    |  |    |  |    |  |
|   |  |   |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |    |                                 |  |   |    |  |    |  |    |  |
|   |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |   |    |                                 |  |   |    |  |    |  |    |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |  |  |  |   |  |   |    |                                 |  |   |    |  |    |  |    |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |   |    |                                 |  |   |    |  |    |  |    |  |
|   |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |    |                                 |  |   |    |  |    |  |    |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |  |  |  |   |  |   |    |                                 |  |   |    |  |    |  |    |  |
| 29b. Signature and title of certifier<br><i>Larry H. Reese MD</i>   |  |   |  | 29c. License number<br><b>D38158</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>8/13/96</b>  |   |  |   |    |                                 |  |   |    |  |    |  |    |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Lisa A. Dikarow MD, 2003 Medical Parkway, Suite 200, Annapolis MD 21401</b>  |  |   |  |  |  |  |   |  |   |    |                                 |  |   |    |  |    |  |    |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 15 1996</b>   |  |   |  | 32. Registrar's Signature<br><i>John Davidson-Randall</i>  |  |  |   |  |   |    |                                 |  |   |    |  |    |  |    |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-691-0058.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25897

## Certificate of Death

Reg. No.

|  |   |   |  |  |   |  |  |   |
|--|---|---|--|--|---|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>MILTON EARL WILSON</b>                                 |   |  |  | 2. Date of Death<br>Month Day Year<br><b>AUG. 10 1996</b>   |  | 3. Time of Death<br><b>8:25 pm</b>         |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>132 W. EARLEIGH HEIGHTS ROAD</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>SEVERNA PARK</b> |  | 4c. County of Death<br><b>ANNE ARUNDEL</b> |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>246-64-1939</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>53</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                              | 8. Date of Birth (Month, Day, Year)<br><b>SEPT. 1 1942</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>NORTH CAROLINA</b> |
|  | Usual Residence of Decedent   |   |  |  |   |  |  |   |
| 10a. State<br><b>MARYLAND</b>  |   | 10b. County<br><b>ANNE ARUNDEL</b>  |  | 10c. City, Town or Location<br><b>SEVERNA PARK</b>   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |
| 10e. Street and Number<br><b>132 W. EARLEIGH HEIGHTS ROAD</b>  |   |   |  | 10f. Zip Code<br><b>21146</b>  |   | 10g. Citizen of What Country?<br><b>US</b>   |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1961-64</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>  |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>0</b>  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CORRECTIONAL OFFICER</b>   |   | 16b. Kind of Business/Industry<br><b>MARYLAND HOUSE OF CORRECTIONAL</b>  |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>VERNON WHITE --- EUGENE WILSON</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>JESSIE MAY</b>   |   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>DONNA WILSON (WIFE)</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>132 W. EARLEIGH HEIGHTS RD. SEVERNA PK., MD. 21146</b>                                   |   |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MARYLAND VETERAN CEME.</b>   |  | Date<br><b>8/15/96</b>   |   | 20c. Location - City or Town, State<br><b>CROWNSVILLE, MD.</b>   |  |   |
| 21. Signature of Funeral Service Licensee<br><b>Harry B. Reese</b>   |   |   |  | 22. Name and Address of Facility<br><b>WM. REESE &amp; SONS MORTUARY, P.A.<br/>821 WEST ST. ANNAPOLIS, MD. 21401</b>   |   |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>a. <b>Metastatic Adenocarcinoma of the Lung with</b><br>Due to (or as a consequence of):<br>b. <b>Brain and Bone Metastases 1 mo.</b><br>Due to (or as a consequence of):<br>c. <b>Adenocarcinoma of the Lung</b><br>Due to (or as a consequence of):<br>d. <b>7 mos.</b> |   |   |  |  |   |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |
|  |   |   |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |
|  |   |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |
|  |   | 28d. Describe how Injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |
| 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |  |  |   |  |  |   |
| 29b. Signature and title of certifier<br><b>Julia Davidson-Randall</b>   |   |   |  | 29c. License number<br><b>031551</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>August 13, 1996</b>  |  |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Russell A. Deluca 1600 S. Crain Highway, C/P2 Burnie, Md. 21061</b>   |   |   |  |  |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>AUG 15 1996</b>  |   | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>  |  |  |   |  |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25898

## Certificate of Death

Reg. No.

|  |  |  |   |   |  |  |  |  |
|--|--|--|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>PEGGY JOYCE WEBSTER  |  |   |   | 2. Date of Death<br>Month Day Year<br>August 6, 1996   |  | 3. Time of Death<br>0216 AM  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>PENINSULA REGIONAL MEDICAL CENTER  |  |   |   | 4b. City, Town, or Location of Death<br>SALISBURY  |  | 4c. County of Death<br>WICOMICO  |  |
| Funeral<br>Director  | 5. Social Security Number<br>217-30-8922   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>65 Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>December 21, 1930   | 9. Birthplace (State or Foreign Country)<br>Maryland |
|  | Usual Residence of Decedent  |  |   |   |  |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>Maryland   |  | 10b. County<br>Wicomico   |   | 10c. City, Town or Location<br>Salisbury   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|  | 10e. Street and Number<br>213 Potomac Ave.   |  |   |   | 10f. Zip Code<br>21804   |  | 10g. Citizen of What Country?<br>USA   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 Collegia (1-4 or 5+) 0   |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Lab technician  |  | 16b. Kind of Business/Industry<br>PRMC (hospital)  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Edwin Shores  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Sadie Shores  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Carl David Webster/spouse  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>213 Potomac Ave., Salisbury, MD 21804   |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Wicomico Memorial Park  |   | Data<br>8/9/96   |  | 20c. Location - City or Town, State<br>Salisbury, MD   |  |
|  | 21. Signature of Funeral Service Licensee<br>David Thompson MO1051   |  |   |   | 22. Name and Address of Facility<br>Holloway Funeral Home<br>501 Snow Hill Rd., Salisbury, MD 21804  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Anoxic Encephalopathy<br>Due to (or as a consequence of):<br>b. Asystole<br>Due to (or as a consequence of):<br>c. Respiratory Arrest<br>Due to (or as a consequence of):<br>d. Coronary Artery Disease with LV Dysfunction Years<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |  |  |  |
|  | Approximate Interval Between Onset and Death<br>16 hours<br>16 hours<br>16 hours   |  |   |   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>End Stage Renal Disease Anemia<br>Peripheral Vascular Disease Mitral Valve Regurgitation<br>Diabetes mellitus  |  |  |   |   |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year) |   | 28b. Time of injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |   | 28d. Describe how injury occurred   |  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |   |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |   |  |  |  |  |
| 29b. Signature and title of certifier<br>Joseph Cindarella, M.D.   |  |  |   | 29c. License number<br>044069   |  | 29d. Date signed (Month, Day, Year)<br>8.6.96  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>JOSEPH CINDARELLA, M.D. 104 MILLARD ST SUITE 104 SALISBURY, MD 21801   |  |  |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>AUG 08 1996   |  |  |   | 32. Registrar's Signature<br>John Davidson Randall  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25899

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DARLENE MAE ZIMMERMAN

2. Date of Death

Month August Day 16 Year 1996

3. Time of Death

10:45 AM

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital Center

4b. City, Town, or Location of Death

Clinton

4c. County of Death

PRINCE GEORGE'S

Funeral  
Director

5. Social Security Number

190-22-7084

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 6 1931

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

White Plains

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4571 Tate Street

10f. Zip Code

20695

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William M. Campbell

18. Mother's Name (First, Middle, Maiden Surname)

Janet M. Durborow Campbell

19a. Informant's Name/Relationship (Type, Print)

William T. Zimmerman (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4571 Tate Street White Plains, MD 20695

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mt Rest Cemetery

Date

8-21-96

20c. Location - City or Town, State

La Plata, MD

21. Signature of Funeral Service Licensee

M00173

22. Name and Address of Facility

J.H. Eberwein Mortuary  
4433 White Pls La White Plains, MD 2069523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

e. Renal failure

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Diabetes Mellitus

Due to (or as a consequence of):

d. Carcinoma of the Liver

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D 16646

29d. Date signed (Month, Day, Year)

August 17, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen G. Goldberger MD 7801 Old Branch Ave # 202 Clinton, MD

31. Date filed (Month, Day, Year)

AUG 19 1996

32. Registrar's Signature

Julia Davidson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

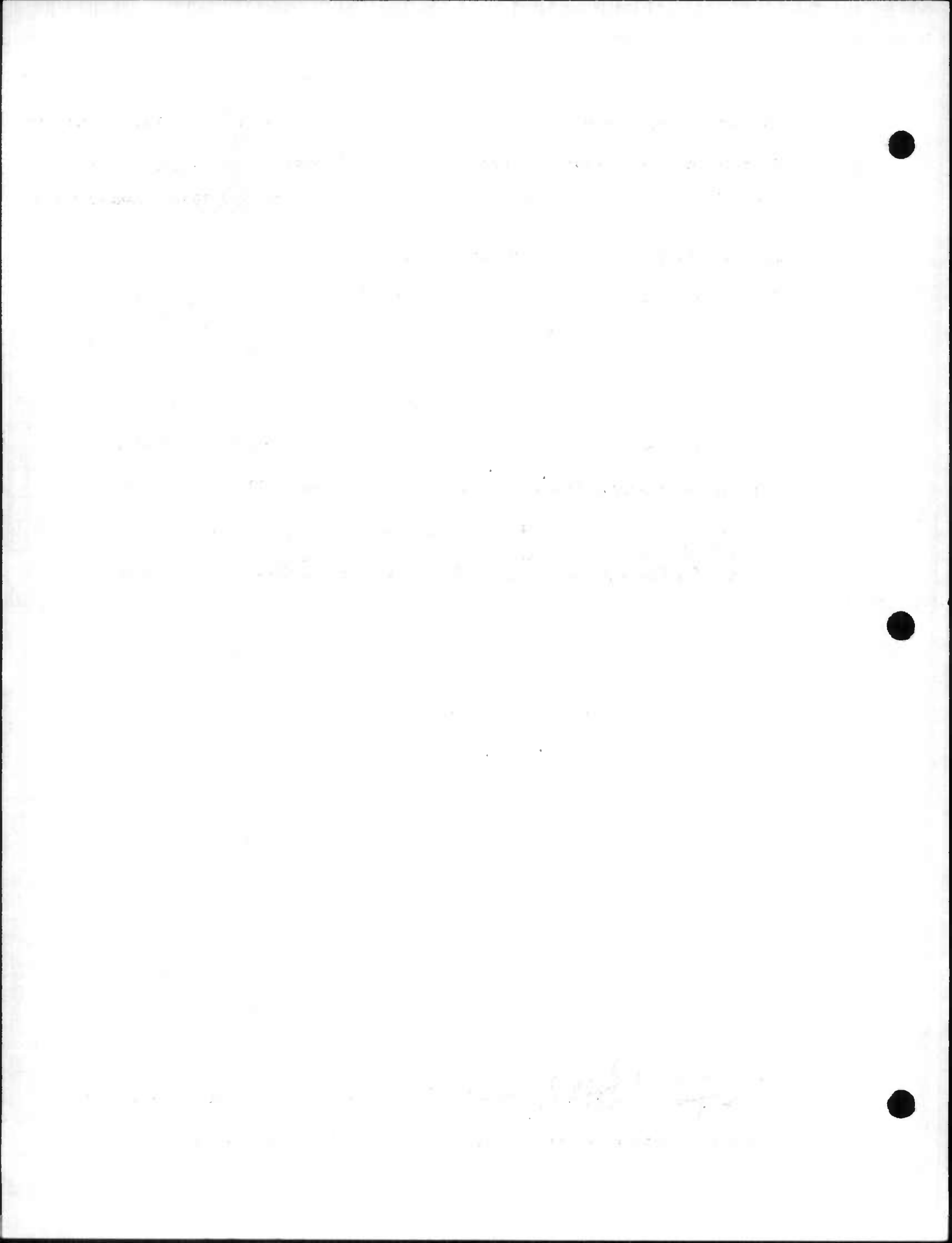
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25900

## Certificate of Death

Reg. No.

|  |   |   |   |  |  |  |   |  |
|--|---|---|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>OTTI ZBANEK</b>  |   |   |  | 2. Date of Death<br>Month Day Year<br><b>AUGUST 1, 1996</b>  |  | 3. Time of Death<br><b>4:50p.m.</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>HOLY CROSS HOSPITAL</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>SILVER SPRING</b>   |  | 4c. County of Death<br><b>MONTGOMERY</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>577-26-2683</b>   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>96</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>AUGUST 10, 1899</b>   | 9. Birthplace (State or Foreign Country)<br><b>CZECHOSLOVAKIA</b>  |
|  | Usual Residence of Decedent   |   |   |  |  |  |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MARYLAND</b>   |   | 10b. County<br><b>MONTGOMERY</b>  |  | 10c. City, Town or Location<br><b>SILVER SPRING</b>  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br><b>XX</b>  |  |
|  | 10e. Street and Number<br><b>2700 BARKER ST.</b>  |   |   |  | 10f. Zip Code<br><b>20910</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b>  |   | College (1-4or 5+)  |  | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>GIFT WRAPPER</b>   |  | 18b. Kind of Business/Industry<br><b>PRIVATE</b>  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>UNKNOWN SINDELAR</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>UNKNOWN</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>PAMELA STEVENSON FORD/GRANDDAUGHTER</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>74 LOCUST LANE EDINBURG, VIRGINIA 22824</b>  |  |   |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>METROPOLITAN CREMATORY</b>   |  | Data<br><b>AUG. 7</b>  |  | 20c. Location - City or Town, State<br><b>ALEXANDRIA, VIRGINIA</b>  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Kimberly C. Brooker-Tomic</i>   |   |   |  | 22. Name and Address of Facility<br><b>MARSHALL'S FUNERAL HOME<br/>4308 SUITLAND ROAD SUITLAND, MD 20746</b>   |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. PNEUMONIA</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   |   |  |  |  |   | Approximate Interval Between Onset and Death<br><b>2 days</b>  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |   |  |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>                  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   | 28d. Describe how Injury occurred  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><i>Daya Sharma MD</i>  |   | 29c. License number<br><b>D41119</b>             |  | 29d. Date signed (Month, Day, Year)<br><b>Aug, 02, 96</b>                            |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DAYA SHARMA 50, W. EDMONSTON DRIVE #401 Rockville MD 20852</b>  |   |   |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 09 1996</b>  |   | 32. Registrar's Signature<br><i>John Andrew Ruckel</i>  |   |  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25901

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DELORES E.

2. Date of Death

Month Day Year  
July 30, 1996

3. Time of Death

2205

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number

160-26-6834

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

65

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
February 4, 1931

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Virginia

10b. County

Accomac

10c. City, Town or Location

Oak Hall

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

Vernon Rd.

10f. Zip Code

234 16

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
11College (1-4 or 5+)  
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

John Bickel

18. Mother's Name (First, Middle, Maiden Surname)

Susana Cochran

19a. Informant's Name/Relationship (Type, Print)

Paul L. Ziegelhofer/spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 87, Oak Hall, VA. 23416

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Salisbury Crematory

Date

7/31/96

20c. Location - City or Town, State

Salisbury, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Holloway Funeral Home  
501 Snow Hill Rd., Salisbury, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Necrotizing fasciitis

Due to (or as a consequence of):

b. Perforated Right colon cancer

Due to (or as a consequence of):

c. Perforated Duodenal Ulcer

Due to (or as a consequence of):

d. Cholelithiasis gall bladder

Approximate Interval Between Onset and Death

&lt;1 week

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

44688

29d. Date signed (Month, Day, Year)

July 31, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David C. Kerrigan, MD 500 Riverside Dr., Suite A206, Salisbury, MD 21801

31. Date filed (Month, Day, Year)

AUG 02 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25902

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ALICE L. BROWN

2. Date of Death

Month Day Year  
Aug. 22 96

3. Time of Death

12:15 p.m.

4a. Facility Name (If not institution, give street and number)

BON SECOUR

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

214-18-2578

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

47 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year

Dec. 28, 1946

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

Maryland

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4206 SEIDAL AVENUE

10f. Zip Code

21206

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
11th grade

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cook

16b. Kind of Business/Industry

WHITE COFFEE POT

17. Father's Name (First, Middle, Last)

MONROE F. HACKNEY

18. Mother's Name (First, Middle, Maiden Surname)

ELLEN GUNNELLS

19a. Informant's Name/Relationship (Type, Print)

MARtha Hopkins, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1222 SEMINOLE AVE BALTIMORE MD 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

PABUTUS Memorial Park

Date

8-29-96

20c. Location - City or Town, State

PABUTUS MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

CHARTMAN - Harris F.H.  
5240 RISTERTOWN ROAD  
BALTIMORE, Maryland 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. PANCREATIC CARCINOMA

FEB 1996

Due to (or as a consequence of):

b. METASTASIS TO LIVER

FEB 1996

Due to (or as a consequence of):

c. GASTROINTESTINAL BLEEDING

Aug 1996

Due to (or as a consequence of):

d. PE PNEUMONIA

Aug 1996

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

AORTIC STENOSIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D41430

29d. Date signed (Month, Day, Year)

08-23-96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

821 N. EUTAW ST. #407 BALTIMORE MD 21201

31. Date filed (Month, Day, Year)

AUG 30 1996

32. Registrar

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25903

## Certificate of Death

Reg. No.

|   |   |   |  |  |  |  |  |  |
|---|---|---|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Mary Lou Burmeister</b>  |   |  |  | 2. Date of Death<br>Month <b>08</b> Day <b>27</b> Year <b>96</b> |  | 3. Time of Death<br><b>7:30 PM</b>           |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Univ. Maryland Medical Center 22 S Greene St</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>         |  | 4c. County of Death<br><b>Baltimore CITY</b> |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>155-34-1262</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>51</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                                   | 8. Date of Birth (Month, Day, Year)<br><b>MARCH 15, 1945</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>PHILADELPHIA, PA.</b> |
|   | Usual Residence of Decedent   |   |  |  |  |  |  |  |
| 10a. State<br><b>MARYLAND</b>   |   | 10b. County<br><b>BALTIMORE</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE COUNTY</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
| 10e. Street and Number<br><b>411 WALCOTT ROAD</b>   |   |   |  | 10f. Zip Code<br><b>21206</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>N/A</b>  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>RECEPTIONIST</b>   |  | 16b. Kind of Business/Industry<br><b>LAW INDUSTRY</b>  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>VINCENT FLOOD</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARGARET ABRAMS</b>  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>CHUCK W. WATT, JR. (SON)</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>411 WALCOTT ROAD BALTIMORE, MARYLAND 21206</b>   |  |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>METRO CREMATORY, INC. AUGUST 31, 1996</b>  |  | Date<br><b>AUGUST 31, 1996</b>   |  | 20c. Location - City or Town, State<br><b>BALTIMORE, MARYLAND</b>  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br><b>LASSAUN FUNERAL HOME, INC.<br/>7401 BELAIR ROAD BALTIMORE, MARYLAND 21236-4625</b>  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Sepsis</b><br>Due to (or as a consequence of):<br><br>b. <b>Acquired Immunodeficiency Syndrome</b><br>Due to (or as a consequence of):<br><br>c. <b>Hepatic failure</b><br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |   |   |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
|   |   |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
|   |   |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
|   |   | 28d. Describe how Injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>8491</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>8-27-96</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Elizabeth Stoller, MD UMMS 22 S. Greene Street Baltimore, MD 21201</b>   |   |   |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 30 1996</b>   |   |   |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Physician  
/Medical  
Examiner

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10  
State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25904

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

REBECCA BELKIN

2. Date of Death

Month Day Year  
August 27, 1996

3. Time of Death

1:10 PM

4a. Facility Name (If not institution, give street and number)

Hebrew Home Of Greater Washington

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

161-10-3958

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 17, 1909

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

6121 Montrose Road

10f. Zip Code

20852

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12 Years

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Abraham Harad

18. Mother's Name (First, Middle, Maiden Surname)

Anna Barkan

19a. Informant's Name/Relationship (Type, Print)

Beryl Boshier, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10700 Dundas Oak Court, Burke, Virginia 22015

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Montefiore Cemetery 8/29/1996

Date

20c. Location - City or Town, State

Rockledge, PA

21. Signature of Funeral Service Licensee

Donald C. Stottmeyer

22. Name and Address of Facility

STEIN HEBREW MEMORIAL FUNERAL HOME, INC.

232 CARROLL STREET, N.W., WASHINGTON, D.C. 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

24 HOURS

Due to (or as a consequence of):

b. ISCHEMIC HEART DISEASE

6 YEARS

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CEREBROVASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 8 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Steven Lipson MD

29c. License number

D 05885

29d. Date signed (Month, Day, Year)

Aug 27, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

STEVEN LIPSON 6121 MONTROSE RD, ROCKVILLE, MD

31. Date filed (Month, Day, Year)

AUG 30 1996

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
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Medical Certification: To Be Completed by Physician/Medical Examiner

DATE MYOCARDIAL INFARCTION  
PSYCHIC HEART DISEASE

PSYCHIC HEART DISEASE

STEVEN LIPSON MD D C  
1981 MONITORING AND TREATMENT

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25905

## Certificate of Death

Reg. No.

|  |  |   |  |  |  |  |  |  |
|--|--|---|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Michael Bailey</b>                                  |   |  |  | 2. Date of Death<br>Month <b>August</b> Day <b>25</b> Year <b>1996</b> |  | 3. Time of Death<br><b>9:22 PM</b>   |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>Maryland General Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>          |  | 4c. County of Death<br><b>N/A</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>214-64-8057</b>  |   | 8. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>42</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 27, 1954</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |
|  | Usual Residence of Decedent  |   |  |  |  |  |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>2237 DRUID HILL AVENUE</b>  |  |   |  | 10f. Zip Code<br><b>@ 21217</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Maintenance</b>  |  |  | 16b. Kind of Business/Industry<br><b>Paint Company</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Walter Bailey</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Martha</b>   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Elizabeth Johnson</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2212 Lyndhurst Ave., Balto., MD 21216</b>  |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Zion Cemetery</b>  |  | Date<br><b>8/30</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>  |  |  |
| 21. Signature of Funeral Service Licensed<br><i>Leroy O. Dyett</i>   |  |   |  | 22. Name and Address of Facility<br><b>LEROY O. DYETT &amp; SON FUNERAL HOME, P.A.<br/>4600 LIBERTY HEIGHTS AVE., BALTO. 21207</b>   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Pneumonia</b><br><br>Due to (or as a consequence of):<br><b>Terminal Acquired Immunodeficiency Syndrome</b><br><br>Due to (or as a consequence of):<br><b>Renal Failure</b><br><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  |  | Approximate interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
|  |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner  |  | 10. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br><i>A. Bautista</i>  |  |   |  | 29c. License number<br><b>89233</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>August 25, 1996</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Arwinnah Bautista, M.D. c/o Maryland General Hospital</b>   |  |   |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 30 1996</b>  |  |   |  | 32. Registrar's Signature<br><i>[Signature]</i>  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25906

## Certificate of Death

Reg. No.

|  |  |  |  |  |  |  |  |   |  |  |
|--|--|--|--|--|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>LISA BAKER</b>  |  |  |  |  |  | 2. Date of Death<br>Month <b>Aug</b> Day <b>27</b> Year <b>1996</b>  |   | 3. Time of Death<br><b>3:50 AM</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>3650 Malden Avenue</b>  |  |  |  |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |   | 4c. County of Death<br><b>Baltimore City</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>219-94-5164</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>30</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 23, 1965</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |
|  | Usual Residence of Decedent  |  |  |  |  |  |  |   |  |  |
| To Be Completed by Funeral Director                                  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Baltimore City</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
|  | 10e. Street and Number<br><b>3650 Malden Avenue</b>  |  |  |  | 10f. Zip Code<br><b>21211</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |  |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b> |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>In Own Home</b>   |   |  |  |
| To Be Completed by Physician/Medical Examiner                        | 17. Father's Name (First, Middle, Last)<br><b>Russell Irving Baker</b>   |  |  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marian Ann Heim</b>  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Marian Ann Baker (Mother)</b>   |  |  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3650 Malden Avenue Baltimore, Maryland 21211</b> |   |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parkwood Cemetery</b>   |  | Date<br><b>8/30/96</b>   |   | 20c. Location - City or Town, State<br><b>Parkville, Maryland</b>  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Tracey Henss Carpenter</i>   |  |  |  | 22. Name and Address of Facility<br><b>Burgee-Henss Funeral Home</b><br><b>3631 Falls Road Baltimore, Maryland 21211</b>   |  |  |   |  |  |
| Physician<br>/Medical<br>Examiner                                    | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. METASTATIC MELANOMA</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b.</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b> |  |  |  |  |  |  |   | Approximate Interval Between Onset and Death<br><b>5 YEARS</b>   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  |  |  |  |  |  |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  |  |  |  |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>HOME</b> |  |  |  |  |   |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred  |  |
|  |  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br><i>John B. McGibbon M.D.</i>  |  | 29c. License number<br><b>006933</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>8-28-96</b>  |   |  |  |
| State Registrar  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JOHN B. MCGIBBON M.D. 101 W. READ ST. SUITE 719 BALTIMORE MD 21201</b>  |  |  |  |  |  |  |   |  |  |
|  | 31. Date filed (Month, Day, Year)<br><b>AUG 30 1996</b>  |  | 32. Registrar's Signature<br><i>John B. McGibbon</i>   |  |  |  |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25907

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RICHARD BERNARD CAMPBELL

2. Date of Death

Month Day Year  
AUGUST 25 1996

3. Time of Death

4 05 P.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

LIBERTY MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

214-38-4003

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

56 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
APR 14 1940

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2008 N. BENTLEY STREET

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

Collegiate (1-4 or 5+)

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

JANITOR

16b. Kind of Business/Industry

PRIVATE BUSINESS

17. Father's Name (First, Middle, Last)

RICHARD A. CAMPBELL

18. Mother's Name (First, Middle, Maiden Surname)

LOUISE LEE

19a. Informant's Name (Relationship (Type, Print))

ROBIE CAMPBELL, WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1715 LEXINGTON STREET BALTIMORE, MD 21223

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

NEW CATHEDRAL CEM. 8/29/96

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

Jenny Harris

22. Name and Address of Facility

CHATMAN - BALL'S Funeral Home  
5540 REISTERSTOWN ROAD  
BALTIMORE, MARYLAND 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. BILATERAL PNEUMONIA WITH SHOCK

UNKNOWN

Due to (or as a consequence of):

b. HEPATO-RENAL SYNDROME

UNKNOWN

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

INTRA-VENOUS DRUG USE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

SUDHIR D. PATEL MD

29c. License number

D 23300

29d. Date signed (Month, Day, Year)

AUGUST 25 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUDHIR D. PATEL

Liberty Medical Center  
2600 LIBERTY BLVD. BALTIMORE, MD 21213

31. Date filed (Month, Day, Year)

AUG 30 1996

32. Registrar's Signature

John P. Pate

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



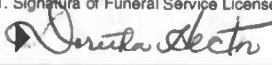
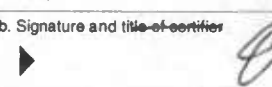
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25908

## Certificate of Death

Reg. No.

|   |  |  |   |   |  |  |
|---|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>WEDNESDAY CHILDS</b>  |  | 2. Date of Death<br>Month Day Year<br><b>AUGUST 28, 1996</b>  |   | 3. Time of Death<br><b>17:56 P</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>GOOD SAMARITAN ICU</b>  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |   | 4c. County of Death<br><b>N/A</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>220-90-4440</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>22</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>9-3-73</b> |
|   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |  |   |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>N/A</b>   |   | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  |
|   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |   |  |  |
|   | 10e. Street and Number<br><b>4004 NORFOLK AVENUE</b>   |  | 10f. Zip Code<br><b>21216</b>   |   | 10g. Citizen of What Country?<br><b>US</b>   |  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b><br>College (1-4 or 5+) <b>-0-</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CLERK</b> |  |  |
| 16b. Kind of Business/Industry<br><b>FOOD</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>GREGORY CHAPMAN</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>PORTIA CHILDS</b>   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>VINITIA PAYNE (GOD MOTHER)</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4004 NORFOLK AVE. BALTIMORE, MARYLAND 21216</b>  |   |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ARBUTUS MEM. PK.</b>  |   | 20c. Location - City or Town, State<br><b>9/5/96 BALTIMORE, MARYLAND</b>  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>PHILLIPS FUNERAL HOME</b><br><b>1721 N. MONROE ST. BALTIMORE, MD. 21217</b>   |   | 22. Name and Address of Facility  |  |  |
| 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Blunt force injuries with complications</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. _____ Due to (or as a consequence of):<br>c. _____ Due to (or as a consequence of):<br>d. _____ |  | Approximate Interval Between Onset and Death   |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |   |  |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   |   |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)<br><b>4-23-96</b>   |   | 28b. Time of Injury<br><b>Unknown</b>   |  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred<br><b>subject beaten</b>   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>street</b>                   |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>corner of Carlize &amp; Hillon St</b>  |  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |  |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>OCME</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>AUGUST 29, 1996</b>   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>David R. Fowler 111 Penn Street, Baltimore, Maryland 21201</b>   |  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 30 1996</b>   |  |  |   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



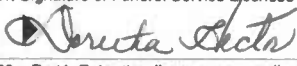


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 25909

Reg. No.

|  |  |   |   |  |  |   |  |   |  |
|--|--|---|---|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Ethel Conyer</b>  |   |   |  | 2. Date of Death<br>Month <b>August</b> Day <b>28</b> Year <b>1996</b>   |   | 3. Time of Death<br><b>8:25 PM</b>   |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Johns Hopkins Geriatric Center</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |   | 4c. County of Death<br><b>Baltimore City</b>   |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>21422 9585</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.                             | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth<br>(Month, Day, Year)<br><b>March 9, 1914</b>                                 | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |  |
|  | Usual Residence of Decedent  |   |   |  |  |   |  |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>  |   | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
|  | 10e. Street and Number<br><b>2528 W. BALTIMORE STREET</b>  |   |   |  | 10f. Zip Code<br><b>21223</b>  |   | 10g. Citizen of What Country?<br><b>US</b>   |   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br><b>BLACK</b>                                 |   |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>12</b>  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>HOUSE WIFE</b>                 |  | 16b. Kind of Business/Industry<br><b>DOMESTIC</b>  |   |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>EMMIT DINKINS</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ELSIE GIBBS</b>  |   |  |   |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>DOLORSE BRADFORD (DAUGHTER)</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4713 WRENDWOOD AVE. BALTIMORE, MARYLAND 21212</b>  |   |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MD. NAT. MEM. PK.</b>  |  | Date<br><b>9/4/96</b>  |   | 20c. Location - City or Town, State<br><b>LAUREL, MARYLAND</b>                                 |   |  |
|  | 21. Signature of Funeral Service Licensee<br> <b>CFSP #281</b>   |   |   |  | 22. Name and Address of Facility<br><b>PHILLIPS FUNERAL HOME 1721 N. MONROE ST. BALTIMORE, MD. 21217</b>   |   |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Pulmonary edema</b><br>Due to (or as a consequence of):<br>b. <b>CHF/CAD</b><br>Due to (or as a consequence of):<br>c. <b>CVA</b><br>Due to (or as a consequence of):<br>d. <b>Parkinson's disease</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |   |   |  |  |   |  |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |   |  |  |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HTN, pressure ulcers, dementia group A strep colonization, anemia Seizures</b>  |  |   |   |  |  | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                      |  | 28d. Describe how injury occurred   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |   |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>D28461</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>8.29.96</b>   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Richard Bennett 5505 Hopkins Bayview Balto, MD 21224</b>  |  |   |   |  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 30 1996</b>  |  | 32. Registrar's Signature<br>  |   |  |  |   |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25910

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Helen Cannon

2. Date of Death

Aug 26 1996

3. Time of Death

2:30PM

4a. Facility Name (If not institution, give street and number)

Univ of MD Med Ctr. 22 South Greene St

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

218-62-7304

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept 20, 1922

9. Birthplace (State or Foreign Country)

S.C.

Usual Residence of Decedent

10a. State

md

10b. County

Balto

10c. City, Town or Location

Woodlawn

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12 Wyndmour Place

10f. Zip Code

21207

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Waitress

16b. Kind of Business/Industry

Resturant

17. Father's Name (First, Middle, Last)

Jack Jackson

18. Mother's Name (First, Middle, Maiden Surname)

Ellen Jackson

19a. Informant's Name/Relationship (Type, Print)

Paul Robinson - Cousin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

708 Dorchester Rd Balto, md

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

King Memorial AC

Date

8/30/96

20c. Location - City or Town, State

Randallstown, md

21. Signature of Funeral Service Licensee

Shannon Stokes

22. Name and Address of Facility

March F.H. West  
4300 Wabush Ave23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Brady cardia

Due to (or as a consequence of):

b. Pulmonary Embolism

Due to (or as a consequence of):

c. Breast Cancer

Due to (or as a consequence of):

d. Colon Cancer

Approximate  
Interval Between  
Onset and Death8/26 7:00 AM  
→ 2:30PM

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of causa  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of Certifier

John Nahn M.D.

29c. License number

077806

29d. Date signed (Month, Day, Year)

8/26/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Nahn UMMS 22 South Greene St Baltimore, MD.

31. Date filed (Month, Day, Year)

AUG 30 1996

32. Registrar's Signature

John Davidson

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

1914  
The following is a list of the names of the persons who have been elected to the office of the President of the United States since the year 1789.

1789

1792

1796

1800

1804

1808

1812

1816

1820

1824

1828

1832

1836

1840

1844

1848

1852

1856

1860

1864

1868

1872

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State of Maryland / Department of Health and Mental Hygiene

96 25911

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Louis Coleman

2. Date of Death

August 26 1996

3. Time of Death

5:15 PM

4a. Facility Name (If not institution, give street and number)

Liberty Medical Center

4b. City, Town, or Location of Death

Balto

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

216-30-7633

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

61 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb 22, 1935

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

Md

10b. County

N/A

10c. City, Town, or Location

Balto

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3622 Dolfield Ave

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Cement Company

17. Father's Name (First, Middle, Last)

Wallace Coleman

18. Mother's Name (First, Middle, Maiden Summa)

Gladys Eldridge

19a. Informant's Name/Relationship (Type, Print)

Nora Coleman - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3622 Dolfield Ave Balto, Md 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Woodlawn Cemetery

Date

8/30/96

20c. Location - City or Town, State

Woodlawn, Md

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

March F. H. West  
4300 Wabash Ave

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Septicemia

Due to (or as a consequence of):

unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. pneumonia

Due to (or as a consequence of):

unknown

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Status Post Above-knee Amputation 8/22/96

History of Myocardial Infarction

History of Cerebro-Vascular Accidents

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] M.D.

29c. License number

D33583

29d. Date signed (Month, Day, Year)

August 26, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hater Zrebeek, M.D. Liberty Medical Center Baltimore, Md 21215

31. Date filed (Month, Day, Year)

AUG 30 1996

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



## Certificate of Death

Reg. No.

|   |   |  |  |  |  |  |  |   |  |  |  |  |
|---|---|--|--|--|--|--|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>John A. Chaildin</b>   |  |  |  |  |  | 2. Date of Death<br>Month Day Year<br><b>August 29, 1996</b>   |   | 3. Time of Death<br><b>8:38 AM</b>                           |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Franklin Square Hospital</b>   |  |  |  |  |  | 4b. City, Town, or Location of Death<br><b>Essex</b>   |   | 4c. County of Death<br><b>Baltimore</b>                      |  |  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>215-66-3532</b>   |  | 6. Sex<br><b>1</b> M <b>2</b> F  |  | 7. Age (In yrs. last birthday)<br><b>39</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>March 11, 1957</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |  |  |
|   | Usual Residence of Decedent   |  |  |  |  |  |  |   |  |  |  |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>Md</b>   |  | 10b. County<br><b>Baltimore</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  |  |   | 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No          |  |  |  |
|   | 10e. Street and Number<br><b>557 Kingston Rd.</b>   |  |  |  | 10f. Zip Code<br><b>21220</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |  |  |  |  |
|   | 11. Marital Status<br><b>1</b> X Navar Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>N/A</b>   |  |  |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Carpet Installer</b>                |  |  | 16b. Kind of Business/Industry<br><b>Self Employed</b>                  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>John F. Chaildin</b>  |  |  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Laura J. Alimondo</b>  |   |  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. Thomas F. Rauber</b>   |  |  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3553 Grier Nursery Rd. Street, Md. 21154</b> |   |  |  |  |  |
|   | 20a. Method of Disposition<br><b>1</b> X Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Cemetery</b>   |  | Date<br><b>9/3</b>   |   | 20c. Location - City or Town, State<br><b>Baltimore, Md.</b> |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  |  |  | 22. Name and Address of Facility<br><b>Hartley Miller Funeral Home</b><br><b>7527 Harford Rd. Baltimore, Md. 21234</b>                             |  |  |   |  |  |  |  |
| Physician<br>/Medical<br>Examiner             | 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. CARDIAC ARRHYTHMIA</b><br>Due to (or as a consequence of):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |  |  |  |  |  |   |  |  | Approximate Interval Between Onset and Death   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>1</b> X Unknown  |  |
|   | 24a. Was an autopsy performed?<br><b>1</b> X Yes <b>2</b> No  |  |  |  |  |  |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> X Yes <b>2</b> No  |  |
|   | 25. Was case referred to medical examiner?<br><b>1</b> X Yes <b>2</b> No  |  |  |  |  |  |  |   |  |  | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> X ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>8</b> Other (Specify) |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><b>1</b> X Natural <b>5</b> Pending Investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide  |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No   |   | 28d. Describe how injury occurred                            |  |  |  |
|   |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                 |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |  |  |
|   | 29a. Certifier (Check only one)<br><b>1</b> X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |  |  |  |  |   |  |  |  |  |
|   | 29b. Signature and title of certifier<br>  |  |  |  | 29c. License number<br><b>O.C.M.E</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>AUG. 29, 1996</b>  |   |  |  |  |  |
| State Registrar                               | 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br><b>DAVID R. FOWLER 111 Penn Street, Baltimore, Maryland 21201</b>   |  |  |  |  |  |  |   |  |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br><b>AUG 30 1996</b>   |  |  |  | 32. Registrar's Signature<br>                                   |  |  |   |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25913

## Certificate of Death

Reg. No.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>MARY Elizabeth CARTER</b>   |   | 2. Date of Death<br>Month <b>AUGUST</b> Day <b>27</b> Year <b>1996</b>  |  | 3. Time of Death<br><b>4:00 AM</b>   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Good Samaritan Hospital</b>   |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  | 4c. County of Death<br><b>N/A</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>220-30-0316</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>61</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   |
|  | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 5, 1935</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent  |   | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>N/A</b>  |
|  | 10c. City, Town or Location<br><b>Baltimore</b>  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |
|  | 10e. Street and Number<br><b>4820 Arabia Ave.</b>  |   | 10f. Zip Code<br><b>21214</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> Collega (1-4or 5+)                       |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Banquet Manager</b>  |
|  | 16b. Kind of Business/Industry<br><b>Marriott Corp.</b>  |   | 17. Father's Name (First, Middle, Last)<br><b>Edward Flynn</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Florence Boswell</b>   |
|  | 19a. Intendant's Name/Relationship (Type, Print)<br><b>Lynn Carter</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2839 Baneberry Ct., Baltimore, MD 21209</b>   |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Green Mount Crematory</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>  |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |   | 22. Name and Address of Facility<br><b>ALTENBURG FUNERAL HOME, P.A.<br/>6009 Harford Rd., Baltimore, MD 21214</b>                                 |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>HYPOTENSION</b><br>a. Due to (or as a consequence of):<br><b>SEPSIS</b><br>b. Due to (or as a consequence of):<br><b>GANGRENE OF BOTH LOWER EXTREMITIES</b><br>c. Due to (or as a consequence of):<br>d.<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b><br><b>HYPOLYCEMIA</b> |   | Approximate Interval Between Onset and Death<br><b>1 HR</b><br><b>2 WEEKS</b><br><b>2 WEEKS</b>   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b><br><b>HYPOLYCEMIA</b>   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
| 28d. Describe how injury occurred  |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>John W. Boalwin - MD RESIDENT</b>   |   | 29c. License number<br><b>D 47861</b>  |  |
| 29d. Date signed (Month, Day, Year)<br><b>AUGUST 27, 1996</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JOSEPH AKWASI BOATEING GOOD SAMARITAN HOSP, BALTIMORE MD 21239</b>   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 30 1996</b>  |  | 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar





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State of Maryland / Department of Health and Mental Hygiene

96 25914

## Certificate of Death

Reg. No.

ITEM#7 8738 8/30/96ag per ME

|  |  |   |   |                                      |  |  |  |   |  |  |  |  |
|--|--|---|---|--------------------------------------|--|--|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>SARAH CAYONAN</b>   |   |   |                                      |  |  | 2. Date of Death<br>Month <b>08</b> Day <b>22</b> Year <b>96</b>   |   | 3. Time of Death<br><b>20:49</b>   |  |  |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>University of Maryland Hospital Baltimore</b>   |   |   |                                      |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |   | 4c. County of Death<br><b>Baltimore</b>  |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>163-18-1881</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |                                      | 7. Age (In yrs. last birthday)<br><b>50+</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>unknown</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>unknown</b>                                     |  |  |  |
|  | Usual Residence of Decedent  |   |   |                                      |  |  |  |   |  |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>none</b>  |                                      | 10c. City, Town or Location<br><b>Baltimore</b>  |  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |  |
|  | 10e. Street and Number<br><b>701 W. Fayette Street</b>   |   |   |                                      | 10f. Zip Code<br><b>21201</b>  |  | 10g. Citizen of What Country?<br><b>yes-U.S.A.</b>   |   |  |  |  |  |
|  | 11. Marital Status <b>unknown</b><br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>unknown</b> College (1-4or 5+) <b>unknown</b>  |   |   |                                      | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>unemployed</b>   |  |  | 16b. Kind of Business/Industry<br><b>none</b>                           |  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Peter Bramble</b>  |   |   |                                      |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>unknown</b>  |   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Vera Carmichael/Friend</b>  |   |   |                                      |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2032 McCullough Street-Baltimore, Maryland 21201</b> |   |  |  |  |  |
|  | 20a. Method of Disposition <b>in</b><br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>State rem.</b>  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |                                      | Data   |  | 20c. Location - City or Town, State  |   |  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Ronald S. Wade, Director</b>   |   |   |                                      |  |  | 22. Name and Address of Facility<br><b>State Anatomy Board-655 W. Baltimore Street<br/>Baltimore, Maryland 21201-1559</b>                                |   |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Atherosclerotic Heart Disease</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Congestive Heart Failure</b><br>Due to (or as a consequence of):<br><br><b>c. Chronic Deep Venous Thrombosis</b><br>Due to (or as a consequence of):<br><br><b>d.</b> |   |   |                                      |  |  |  |   |  |  | Approximate Interval Between Onset and Death   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Congestive Heart Failure</b><br><b>Chronic Deep Venous Thrombosis</b>   |   |   |                                      |  |  |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |                                      |  |  |  |   |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M             |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how injury occurred                                       |  |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>Ronald S. Wade</b>  |   | 29c. License number<br><b>038437</b> |  | 29d. Date signed (Month, Day, Year)<br><b>August 22, 1996</b>                    |  |   |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>South State Oskela 225 Greene Street, Baltimore, Maryland</b>   |  |   |   |                                      |  |  |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 30 1996</b>  |  | 32. Registrar's Signature<br><b>J. Davidson-Randall</b>   |   |                                      |  |  |  |   |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25915

|  |   |  |   |  |  |  |   |  |
|--|---|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>WILLIAM CALDWELL</b>   |  |   |  | 2. Date of Death<br>Month <b>August</b> Day <b>27</b> Year <b>1996</b>   |  | 3. Time of Death<br><b>11:09 AM</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>500 Poplar Grove Street (res.)</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>N/A</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>217-78-6673</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>38</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>May 31, 1958</b>                                  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>N/A</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Usual Residence of Decedent<br><b>500 Poplar Grove Street</b>  |  | 10f. Zip Code<br><b>21223</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                     |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Plumber</b>   |  | 16b. Kind of Business/Industry<br><b>Plumbing</b>  |  | 16c. Collage (1-4 or 5+)<br><b>12th</b>   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>William Caldwell</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Maggie Anderson</b>  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Maggie Caldwell/mother</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>500 Poplar Grove St., Baltimore, MD 21223</b>  |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. zion Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>8/31 Baltimore, Maryland</b>   |  | 20d. Data   |  |
|  | 21. Signature of Funeral Service Licensee<br><i>LeRoy O. Dyett</i>  |  |   |  | 22. Name and Address of Facility<br><b>LEROY O. DYETT &amp; SON FUNERAL HOME, P:A.<br/>4600 LIBERTY HEIGHTS AVE., BALTO. 21207</b>   |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>a. METASTATIC GERM CELL TUMOR</b><br>Due to (or as a consequence of):   |  |   |  |  |  |   |  |
|  | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |   |  |
|  | 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |  |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |   |  |  |  |   |  |
| Physician<br>/Medical<br>Examiner  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 28g. Location (Street and Number or Rural Route Number, City or Town, State)                |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |  |  |   |  |
| State<br>Registrar   | 29b. Signature and title of certifier<br><i>Butheil MD.</i>   |  |   |  | 29c. License number<br><b>D 31650</b>  |  | 29d. Date signed (Month/Day, Year)<br><b>8/28/96</b>  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JOHN GUTHEL, 22 S. GREENE ST. BALTO. MD. 21201</b>   |  |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 30 1996</b>  |   | 32. Registrar's Signature<br><i>Wilson-Randall</i> |   |  |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25916

## Certificate of Death

Reg. No.

|  |  |   |  |   |  |  |  |  |
|--|--|---|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>REGIS THEODORE CARROLL</b>                              |   |  |   | 2. Date of Death<br>Month Day Year<br><b>August 28, 1996</b> |  | 3. Time of Death<br><b>9:30P</b>   |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>Good Samaritan Nursing Center</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>     |  | 4c. County of Death<br><b>N/A</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>208-07-6340</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F<br><b>XXX</b> |   | 7. Age (In yrs. last birthday)<br>Yrs. <b>80</b>             |  | 8. Date of Birth (Month, Day, Year)<br><b>April 28, 1916</b>   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>  |   | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>N/A</b>                                    |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>1019 East Lake Avenue</b>  |  | 10f. Zip Code<br><b>21212</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>                                      |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b> |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>          |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Procurement Officer</b>   |  | 16b. Kind of Business/Industry<br><b>Coast Guard</b>  |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Martin Patrick Carroll</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Morasch</b>  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Dorothy Mae Carroll Wife</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1019 East Lake Avenue Baltimore, Maryland 21212</b>   |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gardens of Faith</b>   |  | 20c. Location - City or Town, State<br><b>9/3/96 Baltimore, Maryland</b>  |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Dennis Stephen Kenakis</i>   |  |   |  | 22. Name and Address of Facility<br><b>Mitchell-Wiedefeld Home<br/>6500 York Road Baltimore, Maryland 21212</b>   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. CORONARY ART. DISEASE</b><br>Due to (or as a consequence of):<br><br><b>b.</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b> |  |   |  |   |  |  | Approximate Interval Between Onset and Death<br><b>5min</b>  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cerebrovascular accident &amp; ischemic necrosis</b>  |  |   |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |   |  |  |  |  |
| 29b. Signature and title of certifier<br><i>Charles F. Hoesch</i>  |  |   |  | 29c. License number<br><b>1020390</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>8/30/96</b>                            |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Charles Hoesch 5601 Loch Raven Blvd. Balto MD 21239</b>   |  |   |  | 31. Date filed (Month, Day, Year)<br><b>AUG 30 1996</b>   |  |  |  |  |
| 32. Registrar's Signature<br><i>John Davidson-Randall</i>  |  |   |  |   |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



96 25917

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Lillian Mary Dawson</i>   |  |  |  | 2. DATE OF DEATH<br>MONTH <i>8</i> DAY <i>27</i> YEAR <i>96</i>   |  | 3. TIME OF DEATH<br><i>903 A M</i>  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>216-01-0329</i>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>90</i> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>Nov. 6, 1905</i>                                      |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Vindobona Nursing Home</i>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Braddock Heights</i>  |  | 9c. COUNTY OF DEATH<br><i>Frederick</i>   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><i>Maryland</i>  |  | 10b. COUNTY<br><i>Frederick</i>  |  | 10c. CITY, TOWN OR LOCATION<br><i>Myersville</i>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><i>12745 Stottlemeyer Road</i>   |  |  |  | 10f. ZIP CODE<br><i>21773</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U. S. A.</i>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>White</i>                         |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>8th Grade</i><br>College (1-4 or 5+) <i></i>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>Chief Operator</i>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>A. S. Abell Company</i>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>George Trewolla</i>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Mary Heil</i>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Theresa Wood (Daughter)</i>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>3900 Highland Ct., Myersville, Maryland 21773</i>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Most Holy Redeemer 8/30/96</i>  |  | 20c. LOCATION — City or Town, State<br><i>Baltimore, Maryland</i>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Schimunek Funeral Home Inc.<br/>3331 Brehms Lane, Baltimore, Maryland 21213</i>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Gastrointestinal bleed</i><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><i>M</i>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |  |
|  |  | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
|  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>  |  |  |  | 29c. LICENSE NUMBER<br><i>225553</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>8/27/96</i>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>J.P. Henry 610 9th Ave Brunswick, MD 21716</i>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>Aug 30 1996</i>  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25918

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Clarence M. Donahue

2. Date of Death

Month Day Year

August 25, 1996

3. Time of Death

12:09 p.m.

4a. Facility Name (If not institution, give street and number)

2126 Harman Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

220-20-9965

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Dec. 24, 1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2126 Harman Avenue

10f. Zip Code

21230

10g. Citizen of What Country?

United States

11. Marital Status

☐ Navar Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates: 1953

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Public Utility

17. Father's Name (First, Middle, Last)

(First Name Unknown) Donahue

18. Mother's Name (First, Middle, Maiden Summa)

Rita Cavey

19a. Informant's Name/Relationship (Type, Print)

Doris Thayer/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3010 Huron Street Baltimore, Maryland 21230

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery

Date

Aug 28

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Loudon Park Funeral Home

3620 Wilkens Avenue Baltimore, Maryland 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Approximate Interval Between Onset and Death

10 YEARS

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

e. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending Investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D30182

29d. Date signed (Month, Day, Year)

AUGUST 29, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

William M. Russell, M.D. 3421 Benson Avenue Baltimore, Maryland 21227

31. Date filed (Month, Day, Year)

AUG 30 1996

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indellible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 25919

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

OLIVE DIETZEL

2. Date of Death

Month Day Year  
AUGUST 29 1996

3. Time of Death

0047

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

214-20-0268

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Mar 18, 1910

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Sykesville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2409 Nickoles Drive

10f. Zip Code

21784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Unknown

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Quality Control Supervisor

16b. Kind of Business/Industry

Pharmaceutical Manufacturing

17. Father's Name (First, Middle, Last)

Frederick

Eisel

18. Mother's Name (First, Middle, Maiden Summa)

Mamie

Hanley

19a. Informant's Name/Relationship (Type, Print)

Mr. Gary Scott, Step Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12215 Tildenwood Drive Rockville, MD 20852

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lake View Mem. Park

Date

8/31

20c. Location - City or Town, State

Sykesville, MD

21. Signature of Funeral Service Licensee

Stephen M Jenkins

22. Name and Address of Facility

Loring Byers Funeral Directors, Inc.

8728 Liberty Road Randallstown, MD 21133

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. DUE TO (or as a consequence of):

HYPERTENSIVE CARDIOMYOPATHY

Approximate Interval Between Onset and Death

5 YEARS

b. DUE TO (or as a consequence of):

c. DUE TO (or as a consequence of):

d. DUE TO (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE, RESPIRATORY

FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 8 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Kristin Thomas, MD RESIDENT

29c. License number

M6161

29d. Date signed (Month, Day, Year)

AUGUST 29, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KRISTIN THOMAS, MD TOWER 110 JOHNS HOPKINS HOSPITAL

31. Date filed (Month, Day, Year)

AUG 30 1996

32. Registrar's Signature

Jana Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25920

## Certificate of Death

Reg. No.

|   |  |  |  |  |  |  |  |   |   |  |
|---|--|--|--|--|--|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Michael John DEFAZIO</b>  |  |  | 2. Date of Death<br>Month <b>August</b> Day <b>28</b> Year <b>1996</b> |  |  | 3. Time of Death<br><b>11:25p.m.</b>   |   |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Franklin Square Hospital</b>  |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>               |  |  |  |   |   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>213-07-2596A</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>6/29/1917</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>Baltimore, Md</b>  |  |
|   | Usual Residence of Decedent  |  |  |  |  |  |  |   |   |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Harford</b>  |  | 10c. City, Town or Location<br><b>Belair</b>   |  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|   | 10e. Street and Number<br><b>1118 Jade Drive</b>   |  |  |  | 10f. Zip Code<br><b>21014</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b> College (1-4or 5+) <b></b>   |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Tractor Operator</b>   |  |  | 16b. Kind of Business/Industry<br><b>Bethlehem Steel</b>                |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Antonio DeFazio</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Bernardina Lordo</b>   |  |  |   |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print) <b>Daughter</b><br><b>Joan DeFazio Proctor</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1118 Jade Drive Belair, MD 21014</b>   |  |  |   |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holly Hill Cemetery</b>   |  |  | 20c. Location - City or Town, State<br><b>8/31/96 Baltimore, MD</b>     |   |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |  |  | 22. Name and Address of Facility<br><b>Joseph N. Zannino Jr. F.H.<br/>263 S. Conkling St. Baltimore, Md. 21224</b>   |  |  |   |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Respiratory failure</b><br>Due to (or as a consequence of):<br><br>b. <b>Pneumonia</b><br>Due to (or as a consequence of):<br><br>c. <b>Multiple myeloma</b><br>Due to (or as a consequence of):<br><br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |  |  |  |  |   |   |  |
|   | Approximate Interval Between Onset and Death<br><br>2 days<br><br>2 days<br><br>3 years  |  |  |  |  |  |  |   |   |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Congestive heart failure, Atrial fibrillation</b>   |  |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |   |  |
|   |  |  |  |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |   |   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   | 28d. Describe how injury occurred   |  |
|   |  |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |   |   |  |
|   | 29b. Signature and title of certifier<br>  |  |  |  | 29c. License number<br><b>R1777</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>August 29, 1996</b>  |   |   |  |
|   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Dr. Monique Langston 9000 Franklin Square Drive Baltimore, Maryland 21237</b>   |  |  |  |  |  |  |   |   |  |
|   | 31. Date filed (Month, Day, Year)<br><b>AUG 30 1996</b>  |  | 32. Registrar's Signature<br>  |  |  |  |  |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25921

## Certificate of Death

Reg. No.

|  |   |   |  |  |  |   |   |  |
|--|---|---|--|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Albert W. Fitzhugh, Sr.</b>              |   |  |  | 2. Date of Death<br>Month Day Year<br><b>Aug 24 1996</b> |   | 3. Time of Death<br><b>0116 AM</b>                          |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>Sinai Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b> |   | 4c. County of Death<br><b>N/A</b>                           |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>213-03-8780</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.         |   | 8. Date of Birth<br>Month, Day, Year<br><b>Oct 26, 1917</b> |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                             |   | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>N/A</b>                                |   | 10c. City, Town or Location<br><b>Baltimore</b>             |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 10e. Street and Number<br><b>4011 PENHURST AVE</b>  |  | 10f. Zip Code<br><b>21215</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                     |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 years</b><br>College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Cement Finisher</b>                           |  | 16b. Kind of Business/Industry<br><b>Maryland Department of</b>  |  |   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>JOHN RICHARD FITZHUGH</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>MAMIE MADDOX</b>   |  |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Maria Fitzhugh, wife</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4011 PENHURST AVE Baltimore, Md 21215</b>  |  |   |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Carrisa Forest V.A. Cem</b>  |  | 20c. Location - City or Town, State<br><b>8-29-96 Durges Mills, Md</b>   |  |   |   |  |
| 21. Signature of Funeral Service Licensee<br><b>Gray Harris</b>  |   | 22. Name and Address of Facility<br><b>CHATHAM HOSPITALS Funeral Home</b><br><b>340 REISTERSTOWN ROAD</b><br><b>Baltimore, Maryland 21215</b>                 |  |  |  |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. LUNG CANCER</b><br>Due to (or as a consequence of):<br><br><b>b.</b> Due to (or as a consequence of):<br><br><b>c.</b> Due to (or as a consequence of):<br><br><b>d.</b> |   |   |  |  |  |   |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |   |  |  |  |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |  |  |   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |  |  |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>EMPHYSEMA</b>   |   |   |  |  |  |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |  |  |   |   |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |   |  |  |  |   |   |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 28d. Describe how injury occurred  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |  |  |  |   |   |  |
| 29b. Signature and title of certifier<br><b>Matthew McNabney MD</b>  |   | 29c. License number<br><b>D45757</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>AUG 24, 1996</b>   |  |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MATTHEW MCNABNEY 2434 W Belvedere BALD, MD 21215</b>  |   |   |  |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 30 1996</b>  |   | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |  |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25922

## Certificate of Death

Reg. No.

|  |   |  |   |                                      |   |   |   |  |
|--|---|--|---|--------------------------------------|---|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><i>Erma M. Grant</i>  |  |   |                                      | 2. Date of Death<br>Month <i>Aug</i> Day <i>27</i> Year <i>1996</i>   |   | 3. Time of Death<br><i>2:00 AM</i>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>1809 W. Lanvale Street</i>   |  |   |                                      | 4b. City, Town, or Location of Death<br><i>Baltimore</i>  |   | 4c. County of Death<br><i>NA</i>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><i>220-20-2846</i>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |                                      | 7. Age (In yrs. last birthday)<br><i>75</i> Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br><i>Sept 29, 1920</i>                                 |  |
|  | 9. Birthplace (State or Foreign Country)<br><i>MD</i>   |  | 10a. State<br><i>MD</i>   |                                      | 10b. County<br><i>NA</i>  |   | 10c. City, Town or Location<br><i>Baltimore</i>   |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent   |  |   |                                      | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |  |
|  | 10e. Street and Number<br><i>1809 W. Lanvale Street</i>   |  |   |                                      | 10f. Zip Code<br><i>21217</i>   |   | 10g. Citizen of What Country?<br><i>U.S.A.</i>  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>Black</i>                     |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>10th grade</i><br>College (1-4 or 5+) <i>NA</i>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>House wife</i>                    |                                      | 16b. Kind of Business/Industry<br><i>Home</i>   |   |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><i>Arthur Gale</i>   |  |   |                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Lena Cornish</i>  |   |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><i>Marie Cooper - Daughter</i>  |  |   |                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>5312 Belleville Avenue Baltimore, MD 21207</i>  |   |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Parkwood Cemetery</i>  |                                      | 20c. Location - City or Town, State<br><i>Baltimore, MD</i>   |   | 20d. Date<br><i>8/31/96</i>   |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Bladys Warren</i>   |  |   |                                      | 22. Name and Address of Facility<br><i>Martha F. H. West 4300 Walnut Avenue Baltimore, MD 21215</i>   |   |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |                                      |   |   |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |                                      |   |   |   |  |
| Physician<br>/Medical<br>Examiner  | Immediate Cause (Final disease or condition resulting in death)   |  |   |                                      | Approximate Interval Between Onset and Death  |   |   |  |
|  | a. <i>Myocardial Infarction</i><br>Due to (or as a consequence of):   |  |   |                                      |   |   |   |  |
|  | b. <i>Atherosclerotic heart disease</i><br>Due to (or as a consequence of):   |  |   |                                      |   |   |   |  |
|  | c. <i>Chronic obstructive lung disease</i><br>Due to (or as a consequence of):  |  |   |                                      | <i>&gt; 6 years</i>   |   |   |  |
|  | d.  |  |   |                                      |   |   |   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |                                      |   |   |   |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |                                      | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |
|  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |                                      | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)  |                                      | 28b. Time of Injury<br><i>M</i>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | 28d. Describe how injury occurred   |  |   |                                      | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |                                      |   |   |   |  |
| 29b. Signature and title of certifier<br><i>Moges Gebremariam</i>  |   |  |   | 29c. License number<br><i>D18327</i> |   | 29d. Date signed (Month, Day, Year)<br><i>Aug. 30, 1996</i> |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Moges Gebremariam MD 4660 Wilkens Ave Balto MD 21229</i>  |   |  |   |                                      |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><i>AUG 30 1996</i>  |   |  |   |                                      |   |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25923

## Certificate of Death

Reg. No.

|  |  |                     |   |   |  |  |  |  |   |  |
|--|--|---------------------|---|---|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br>Ellen Emelyn Gayle   |                     |   |   | 2. Date of Death<br>Month Day Year<br>Aug 24 1996  |  |  |  | 3. Time of Death<br>7 : am                          |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>2405 Allendale Rd  |                     |   |   | 4b. City, Town, or Location of Death<br>Baltimore  |  |  |  | 4c. County of Death<br>None                         |  |
| Funeral<br>Director  | 5. Social Security Number<br>217-60-4239   |                     | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>82 Yrs. | If Under 1 Year<br>Months Days   |  | If Under 24 Hrs.<br>Hours Min.   |  | 8. Date of Birth (Month, Day, Year)<br>Jun 06, 1914 | 9. Birthplace (State or Foreign Country)<br>Jamaica W.I. |
|  | Usual Residence of Decedent  |                     |   |   |  |  |  |  |   |  |
| To Be Completed by Funeral Director                                  | 10a. State<br>Md   | 10b. County<br>None | 10c. City, Town or Location<br>Baltimore  |   |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |   |  |
|  | 10e. Street and Number<br>2405 Allendale Rd  |                     |   |   | 10f. Zip Code<br>21216   |  | 10g. Citizen of What Country?<br>USA   |  |   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |                     | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) Unknown<br>College (1-4 or 5+) Unknown  |                     | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Nurse                                    |   |  |  | 16b. Kind of Business/Industry<br>Medical  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br>Unknown   |                     |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Emeline Campbell  |  |  |  |   |  |
| Physician<br>/Medical<br>Examiner                                    | 19e. Informant's Name/Relationship (Type, Print)<br>Dorothy King (Daughter-In-Law)   |                     |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6900 Schissler Ave Baltimore, Md. 21207   |  |  |  |   |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |                     | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Woodlawn  |   | Date<br>9-3-96   |  | 20c. Location - City or Town, State<br>Woodlawn Baltimore  |  |   |  |
|  | 21. Signature of Funeral Service Licensee<br>Derrick C. Jones  |                     |   |   | 22. Name and Address of Facility<br>The Derrick C. Jones Funeral Home<br>4611 Park Heights Ave Balto. Md. 21215  |  |  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>BILATERAL MALIGNANT PLEURAL EFFUSIONS<br>Due to (or as a consequence of):<br>METASTATIC BREAST CANCER<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>Non Insulin Dependent Diabetes Mellitus<br>Hypertension |                     |   |   |  |  |  |  |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown<br>24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |                     |   |   |  |  |  |  |   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |                     |   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |                     | 28a. Date of injury (Month, Day Year)   |   | 28b. Time of injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |  | 28d. Describe how injury occurred                   |  |
|  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |                     |   |   | 29b. Signature and title of certifier<br>D. C. Jones MD  |  | 29c. License number<br>D24089  |  | 29d. Date signed (Month, Day, Year)<br>8/26/96      |  |
|  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>A. Osei-Wakum MD 5710 Wabash Ave, Balt Md 21215  |                     |   |   |  |  |  |  |   |  |
|  | 31. Date filed (Month, Day, Year)<br>AUG 30 1996   |                     | 32. Registrar's Signature<br>Don Randall  |   |  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 25924

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Boris Greenberg

2. Date of Death

Month

Day

Year

Aug 24 1996

3. Time of Death

8:30 AM

4a. Facility Name (If not Institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

064-01-2424

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Mar. 28, 1915

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

12001 Old Columbia Pike, Apt. 206

10f. Zip Code

20904

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

2 Years

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Post Office Supervisor

16b. Kind of Business/Industry

United States

Postal Service

17. Father's Name (First, Middle, Last)

Joseph Greenberg

18. Mother's Name (First, Middle, Maiden Surname)

Goldie Vogel

19a. Informant's Name/Relationship (Type, Print)

Ruth A. Greenberg, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12001 Old Columbia Pike, Apt. 206

Silver Spring, Maryland 20904

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

King David Memorial Garden

Date

8/26/1996

20c. Location - City or Town, State

Falls Church, Virginia

21. Signature of Funeral Service Licensee

Donald C. Stottmeyer

22. Name and Address of Facility

STEIN HEBREW MEMORIAL FUNERAL HOME, INC.

232 CARROLL STREET, NW, WASHINGTON, DC 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Ventricular Tachycardia

Approximate Interval Between Onset and Death

minutes

b. Due to (or as a consequence of):

Myocardial Infarct

Sday

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

Coronary Artery Disease

years

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Arnon Kenigberg M.D.

29c. License number

D38435

29d. Date signed (Month, Day, Year)

Aug 24, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Arnon Kenigberg M.D. 10313 Geary Ave. Suite 27 Silver Spring, MD

31. Date filed (Month, Day, Year)

AUG 30 1996

32. Registrar's Signature

John A. Johnson

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

|   |  |  |  |   |  |   |  |  |  |   |  |
|---|--|--|--|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Etta Goldstein</b>   |  |  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Aug. 20, 1996</b>  |  | 3. TIME OF DEATH<br><b>10:50 P M</b>   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-48-8373</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>87</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>July 17, 1909</b>                   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>New York</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Holy Cross Hospital</b>  |  |  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Silver Spring</b>   |  |  |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |  |
| 10a. STATE<br><b>Maryland</b>   |  |  |  |   |  | 10b. COUNTY<br><b>Montgomery</b>  |  |  |  | 10c. CITY, TOWN OR LOCATION<br><b>Wheaton</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |   |  |   |  |  |  |   |  |
| 10e. STREET AND NUMBER<br><b>4011 Randolph Road.</b>  |  |  |  |   |  | 10f. ZIP CODE<br><b>20902</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                                    |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)   |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |   |  |
| Elementary/Secondary (0-12)<br><b>8</b>   |  |  |  | College (1-4 or 5+)<br><b>Housewife</b>   |  |   |  | Own Home   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Morris Fein</b>   |  |  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Hinda Cohen</b>   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Stuart Goldstein</b>   |  |  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>13651 S.W. 77 Ave., Miami, Fla. 33158</b>   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Lakeside Memorial Park 8/23/96</b>  |  |   |  | 20c. LOCATION — City or Town, State<br><b>Miami, Fla.</b>                        |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Ives-Pearson Funeral Homes<br/>Falls Church, Va. 22046</b>   |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>a. Peritonitis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Sepsis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. Pulmonary virus (influenza)</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d. Pneumonia</b> |  |  |  |   |  |   |  |  |  | Approximate interval Between Onset and Death<br><b>Hours</b><br><b>Hours</b><br><b>Hours</b><br><b>Months</b> |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Atrial Hypertrophy, Fracture of femur and tibia, Demerol Stroke and Right hemiparesis</b>  |  |  |  |   |  |   |  |  |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   |  |  |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |   |  |   |  |  |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |   |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |   |  | 28f. LOCATION (Street end Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><br><b>Dr. E. Bruma MD</b>   |  |  |  |   |  | 29c. LICENSE NUMBER<br><b>00 81 88</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8-21-96</b>                            |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>HUGO G. CASZIANI JR 717 PERSHAW DR S.E. MD 20910</b>  |  |  |  |   |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 30 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |  |  |   |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25926

## Certificate of Death

Reg. No.

|  |   |  |  |   |   |  |  |  |
|--|---|--|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>JOHN EMORY GILLESPIE</b>   |  |  |   | 2. Date of Death<br>Month Day Year<br>August 27, 1996   |  | 3. Time of Death<br>5:50p.m.   |  |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>Old Court Nursing Center</b>   |  |  |   | 4b. City, Town, or Location of Death<br><b>Randallstown</b>   |  | 4c. County of Death<br><b>Baltimore</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>217-05-1888</b>   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |   | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Sept 14, 1913</b>                          |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Woodlawn</b>                                       |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yea 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>1711 Forest Park Avenue</b>   |   | 10f. Zip Code<br><b>21207</b>   |  | 10g. Citizen of What Country?<br><b>U S A</b>  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW2</b> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Caucasian</b>          |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>6th Grade</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Supervisor</b>                                   |   | 16b. Kind of Business/Industry<br><b>Bendix</b>   |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Harry Gillespie</b>   |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Isabella Hardy</b>  |  |  |  |
|  | 19e. Informant's Name/Relationship (Type, Print)<br><b>Rosalie Cheuront (Niece)</b>   |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6611 Windsor Mill Rd. Baltimore, MD 21207</b>   |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lorraine Park Cemetery</b>  |   | 20c. Location - City or Town, State<br><b>8-30-96 Woodlawn, Maryland</b>  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Joseph J. Kellner</i>   |  | 22. Name and Address of Facility<br><b>Loring Byers Funeral Directors, Inc.</b><br><b>8728 Liberty Rd. Randallstown, MD 21133-4784</b>                           |   |   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Acute Respiratory Failure</i><br>Due to (or as a consequence of):<br>b. <i>Cerebrovascular accident</i><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |  |   |   |  |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yea 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  |   |   |  |  |  |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |  |  |   |   |  |  |  |
| Physician<br>/Medical<br>Examiner  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|  | 28d. Describe how injury occurred   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
|  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |   |   |  |  |  |
| State<br>Registrar   | 29b. Signature and title of certifier<br><i>Herman Brecher</i>  |  |  |   | 29c. License number<br><b>DO 1317</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>8/29/96</b>                                |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Herman Brecher, M.D. 2337 N. Rolling Rd Baltimore, MD 21244</b>  |  |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 30 1996</b>  |   |  |  | 32. Registrar's Signature<br><i>John Davidson-Randall</i> |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

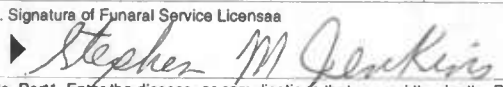

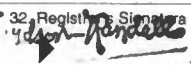
Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Certificate of Death

Reg. No.

|   |   |  |   |                                |   |
|---|---|--|---|--------------------------------|---|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>RUTH ALICE GOSNELL</b>   |  | 2. Date of Death<br>Month <b>AUGUST</b> Day <b>28</b> , Year <b>1996</b>  |                                | 3. Time of Death<br><b>3:30 PM.</b>   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>4043 FRANKLINVILLE RD.</b>   |  | 4b. City, Town, or Location of Death<br><b>NEW WINDSOR</b>  |                                | 4c. County of Death<br><b>Carroll</b>   |
| Funeral<br>Director                           | 5. Social Security Number<br><b>219-12-0241</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.  |
|   | 8. Date of Birth (Month, Day, Year)<br><b>Mar 10, 1917</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |                                |   |
| To Be Completed by Funeral Director           | Usual Residence of Decedent   |  | 10a. State<br><b>Maryland</b>   |                                | 10b. County<br><b>Carroll</b>   |
|   | 10c. City, Town or Location<br><b>New Windsor</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                                |   |
|   | 10e. Street and Number<br><b>4043 Franklinville Road</b>  |  | 10f. Zip Code<br><b>21776</b>   |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:     |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7th Grade</b> College (1-4 or 5+) <b>College</b>    |                                |   |
|   | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>   |                                |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>Thomas M. Bower</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Eva Conaway</b>   |                                |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. Robert LeRoy Gosnell</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4043 Franklinville Road New Windsor, MD 21776</b> |                                |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Pleasant Ridge Cemetery</b>  |                                | 20c. Location - City or Town, State<br><b>8/30 Woodbine, MD</b>   |
|   | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Burrier-Queen Funeral Directors, P.A.<br/>1212 West Old Liberty Road Winfield, MD 21784</b>                    |                                |   |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>Arteriosclerotic Cardiovascular Disease</b>   |  |   |                                | Approximate Interval Between Onset and Death  |
|   | Due to (or as a consequence of):  |  |   |                                |   |
|   | Due to (or as a consequence of):  |  |   |                                |   |
|   | Due to (or as a consequence of):  |  |   |                                |   |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |
|   |   |  |   |                                | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|   |   |  |   |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |
|   | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |                                | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |                                | 28b. Time of Injury<br><b>M</b>   |
|   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28d. Describe how injury occurred   |                                |   |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                |   |
|   | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |                                |   |
|   | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>O.C.M.E.</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>AUGUST 29, 1996</b>   |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DAVID FOWLER M.D. 111 Penn Street, Baltimore, Maryland 21201</b>   |  |   |                                |   |
| State<br>Registrar                            | 31. Date filed (Month, Day, Year)<br><b>AUG 30 1996</b>   |  | 32. Registrar's Signature<br>                                      |                                |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

96 25928

## Certificate of Death

Reg. No.

|  |  |   |   |   |  |   |  |
|--|--|---|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>VIOLA ELIZABETH HOLMES</b>  |   |   |   | 2. Date of Death<br>Month <b>AUG</b> Day <b>22</b> Year <b>1996</b>  |   | 3. Time of Death<br><b>1420</b>  |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>St. Agnes Hospital</b>  |   |   |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |   | 4c. County of Death<br><b>W/A</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-30-2062</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>60</b> Yrs.  | If Under 1 Year<br>Months                                     | If Under 24 Hrs.<br>Hours  | 8. Date of Birth<br>(Month, Day, Year)<br><b>FEB 9, 1936</b>                                | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |
|  | Usual Residence of Decedent<br>10a. State <b>Maryland</b> 10b. County <b>W/A</b> 10c. City, Town or Location <b>Baltimore</b>  |   |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |
| To Be Completed by Funeral Director  | 10e. Street and Number<br><b>3708 LIBERTY HEIGHTS AVE</b>  |   | 10f. Zip Code<br><b>21215</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th grade</b> College (1-4or 5+)   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>SEAMSTRESS</b>                 |   | 16b. Kind of Business/Industry<br><b>Factory</b>   |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>ESSAC T. MERRILL</b>   |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MINNIE U. FOUNTAIN</b>   |   |  |
|  | 19e. Informant's Name/Relationship (Type, Print)<br><b>ALVINIA HOLMES, Daughter</b>  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3708 LIBERTY HEIGHTS AVE BALTIMORE MD 21215</b>  |   |  |
| To Be Completed by Physician/Medical Examiner  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GREENMOUNT CREMATORY</b>   |   | 20c. Location - City or Town, State<br><b>Baltimore, Md</b>  |   |  |
|  | 21. Signature of Funeral Service Licensee<br><b>James Harris</b>   |   | 22. Name and Address of Facility<br><b>CHATHAM - Harris Funeral Home<br/>5540 REISTERSTOWN ROAD<br/>BALTIMORE, MD 21215</b>                       |   |  |   |  |
|  | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>LEIOMYOSARCOMA - METASTATIC</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |   |   |   |  |   | Approximate Interval Between Onset and Death<br><b>2 YEARS</b>   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|  | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28e. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M                                      |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how Injury occurred   |   |   |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |   |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |   |  |   |  |
| 29b. Signature and title of certifier<br><b>[Signature]</b>  |  | 29c. License number<br><b>219419</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>August 22, 1996</b> |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DANA H. GRIFFITHS 900 CATON AVE. BMT. MD 21229</b>  |  |   |   |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 30 1996</b>  |  |   |   |   |  |   |  |

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25929

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Marie Handford

2. Date of Death

August 28, 1996

3. Time of Death

1:33 p.m.

4a. Facility Name (If not institution, give street and number)

4618 Frankford Avenue

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

213-01-0462

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

99 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov 18, 1896

9. Birthplace (State or Foreign Country)

Ireland

Usual Residence of Decedent

10a. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4618 Frankford Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

James Quinn

18. Mother's Name (First, Middle, Maiden Surname)

Bridget (Not Known)

19a. Informant's Name/Relationship (Type, Print)

Florence Dunn

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

409 Main Street Stevensville, Md. 21666

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holy Redeemer Cemetery 8/31/96

Date

20c. Location - City or Town, State

Baltimore Maryland

21. Signature of Funeral Service Licensee

Milton J. Knight Jr.

22. Name and Address of Facility

Leonard J. Ruck, Inc.

5305 Harford Road Baltimore, Maryland 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Peripheral Vascular Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Edward M. Miller

29c. License number

D19473

29d. Date signed (Month, Day, Year)

8-29-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Edward M. Miller, M.D. 5601 Loch Raven Blvd. Baltimore, Maryland

31. Date filed (Month, Day, Year)

AUG 30 1996

32. Registrar's Signature

John A. Miller

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

State  
Registrar





96 25930

item #26, filmg 738, 8/30/96,cyw, per hospital

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |   |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ROBERT L. HOUSTON Sr.</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>AUGUST</b> DAY <b>25</b> YEAR <b>1996</b>  |  | 3. TIME OF DEATH<br><b>2:50 A.M.</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>234-32-7002</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>71</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>FEB. 3, 1925</b>   |   |
| 8. FACILITY NAME (If not institution, give street and number)<br><b>NORTH ARUNDEL Hospital Assn</b>   |  |  |  | 9a. CITY, TOWN OR LOCATION OF DEATH<br><b>Glen Burnie</b>   |  | 9c. COUNTY OF DEATH<br><b>ANNE ARUNDEL</b>   |   |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>Anne Arundel</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Gambrills</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                |   |
| 10e. STREET AND NUMBER<br><b>968 Fall Circle Way</b>  |  |  |  | 10f. ZIP CODE<br><b>21054</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Enlisted</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>US Army</b>  |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Claude Jackson</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Rosa Morris</b>   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Debra Houston</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>968 Fall Circle Way, Gambrills, MD 21054</b>  |  |  |   |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Entombment Lakemnt Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>8/30 Davidsonville, MD</b>  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Hardesty Funeral Home, P.A.<br/>12 Ridgely Ave. Annapolis, MD 21401</b> |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Butler J. Ash</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Hardesty Funeral Home, P.A.<br/>12 Ridgely Ave. Annapolis, MD 21401</b>  |  |  |   |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ASCVD</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> |  |  |  |   |  |  | Approximate interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  |   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |   |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                    |   |
| 28d. DESCRIBE HOW INJURY OCCURED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Jeffrey Buga MD</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D28640</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>AUG 25, 1996</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>2011 Sandy Circle Apt 102 Odenton Md 21113</b>  |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 30 1996</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>James H. Anderson-Randall</i>  |  |   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25931

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LEROY

2. Date of Death

HARCUM Sr.

Month Day Year

AUGUST 25, 1996

3. Time of Death

08:58AM

4a. Facility Name (If not institution, give street and number)

SHOCK TRAUMA UNIT

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

223-242230

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 5, 1910

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10e. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1207 ASHBURTON ST.

10f. Zip Code

21216

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

B.A.

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CARPENTER

16b. Kind of Business/Industry

BUILDING

17. Father's Name (First, Middle, Last)

ELIAS HARCUM

18. Mother's Name (First, Middle, Maiden Surname)

DAISY TURNER

19a. Informant's Name/Relationship (Type, Print)

LEROY HARCUM JR.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

29 N. CULVER ST. BALT. MD, 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WOODLAWN CEM. 8849 WOODLAWN MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of

GARY T. MARCH FUNERAL HOME P.A.  
270 FREDERICK PASS BALT. MD, 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. stab wound of abdomen and multiple

Due to (or as a consequence of):

b. cutting wounds

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☒ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

8-25-96

28b. Time of Injury

06:41 M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Stabbed Subject

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Residence

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1207 Ashburton St

29e. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

AUGUST 26, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David R Fowler

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 30 1996

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.


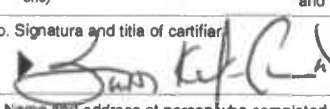
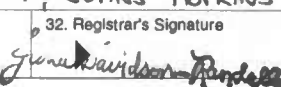
item #1, filgm 738, 8/30/96, cyw, per in

State of Maryland / Department of Health and Mental Hygiene

96 25932

## Certificate of Death

Reg. No.

|  |   |  |   |  |   |   |  |   |
|--|---|--|---|--|---|---|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last) <b>BENJAMIN ADAMS IGNATIUS</b><br><del>BABY BOY IGNATIUS</del>   |  |   |  | 2. Date of Death<br>Month <b>AUGUST</b> Day <b>23</b> Year <b>1996</b>  |   | 3. Time of Death<br><b>9:45pm</b>  |   |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>THE JOHNS HOPKINS HOSPITAL</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE CITY</b>   |   | 4c. County of Death<br><b>N/A</b>  |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>N/A</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (If yrs. last birthday)<br><b>29</b> Yrs.   | If Under 1 Year<br>Months <b>29</b> Days <b>29</b> Hours <b>29</b> Min.   | 8. Date of Birth (Month, Day, Year)<br><b>July 25, 1996</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
|  | Usual Residence of Decedent   |  |   |  |   |   |  |   |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Carroll</b>   |  | 10c. City, Town or Location<br><b>Sykesville</b>  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
|  | 10e. Street and Number<br><b>7118 Carmae Road</b>   |  |   |  | 10f. Zip Code<br><b>21784</b>   |   | 10g. Citizen of What Country?<br><b>United States</b>  |   |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>n/a</b> College (1-4or 5+) <b>n/a</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>n/a</b>                           |  | 16b. Kind of Business/Industry<br><b>n/a</b>  |   |  |   |
|  | 17. Father's Name (First, Middle, Last)<br><b>Joseph C. Ignatius</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Linda Adams</b>   |   |  |   |
| Physician<br>/Medical<br>Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Joseph C. Ignatius (Father)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7118 Carmae Road Sykesville, MD 21784</b>   |   |  |   |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Resthaven Memorial Gardens</b>                                       |  | Date<br><b>8/26</b>   |   | 20c. Location - City or Town, State<br><b>Frederick, Maryland</b>                              |   |
|  | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Burrier-Queen Funeral Directors, P.A.<br/>1212 W. Old Liberty Road Winfield, MD 21784</b>  |   |  |   |
|  | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |   |   |  |   |
|  | 23b. Approximate Interval Between Onset and Death   |  |   |  |   |   |  |   |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | Immediate Cause (Final disease or condition resulting in death)<br><b>a. Hypoplastic Left Heart Syndrome</b><br>Due to (or as a consequence of):  |  |   |  | <b>29 days</b>  |   |  |   |
|  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. DiGeorge's Syndrome</b><br>Due to (or as a consequence of):   |  |   |  | <b>29 days</b>  |   |  |   |
|  | c.  |  |   |  |   |   |  |   |
|  | d.  |  |   |  |   |   |  |   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Thymic Aplasia</b><br><b>Small Cerebellum</b>  |  |   |  |   |   |  |   |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   |
|  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28d. Describe how injury occurred   |   |  |   |
|  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |   |  |   |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |   |   |  |   |
| State Registrar  | 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br><b>D45991</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>August 24, 1996</b>                                  |   |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SUSAN K. McGONE, M.D., JOHNS HOPKINS UNIVERSITY HOSPITAL</b>   |  |   |  |   |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>AUG 30 1996</b>  |   |  |   | 32. Registrar's Signature<br> |   |   |  |   |

Baltimore, Maryland 21215-0020

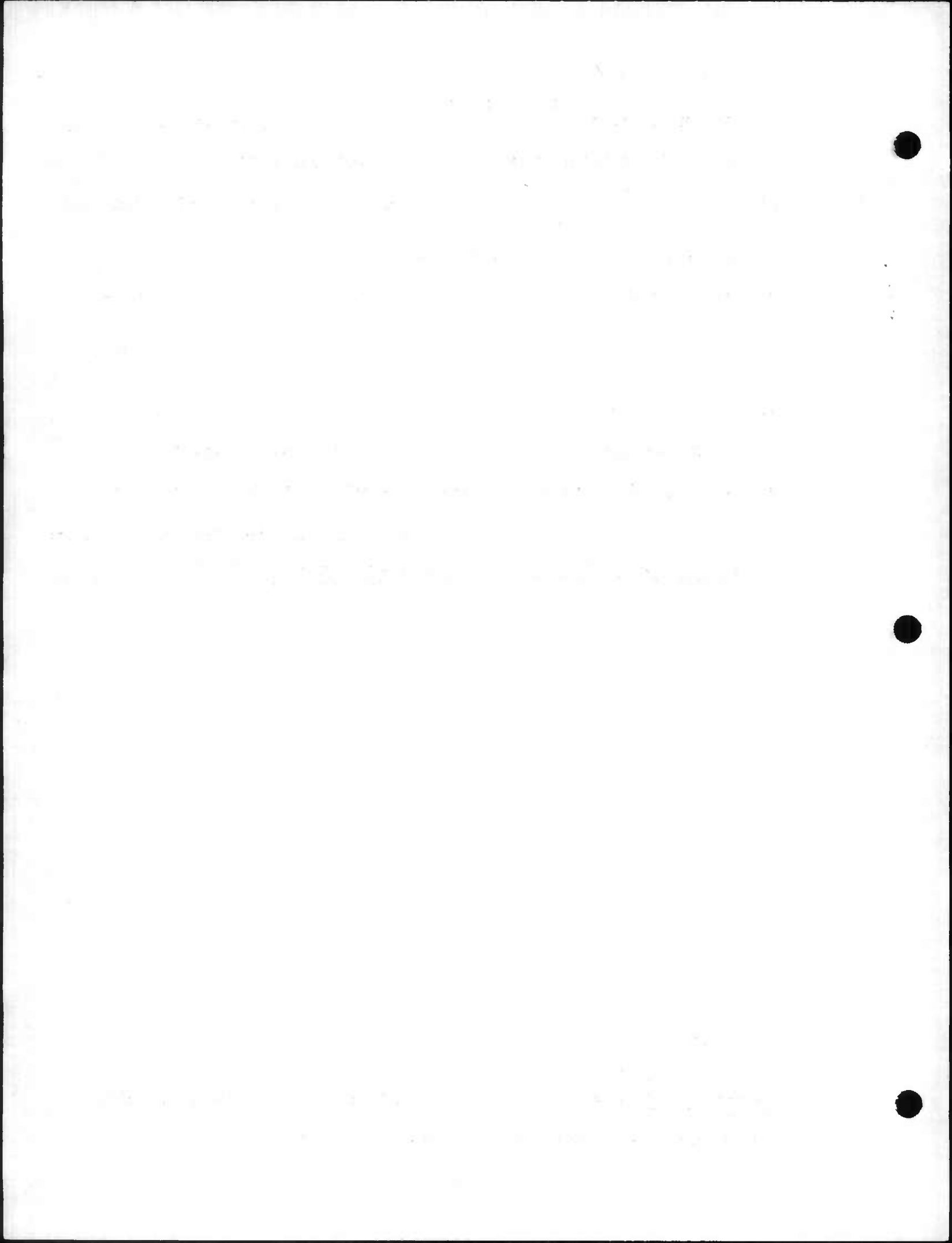
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



|   |  |  |   |  |  |  |  |   |  |
|---|--|--|---|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>OLIVIA JACKSON</b>  |  |   |  | 2. Date of Death<br>Month <b>AUGUST</b> Day <b>25</b> Year <b>1996</b>   |  | 3. Time of Death<br><b>8:05 P.M.</b>   |   |  |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>1918 HARLEM AVE</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>none</b>   |   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>unknown</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>11/5/1915</b>                          |   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>SOUTH CAROLINA</b>  |  | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>N/A</b>  |  | 10c. City, Town or Location<br><b>BALTIMORE</b>                                  |   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>1918 HARLEM AVENUE</b>   |  | 10f. Zip Code<br><b>21217</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                   |   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>          |   |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>BEAUTICIAN</b>  |  | 16b. Kind of Business/Industry<br><b>BEAUTY SALON</b>  |  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>MACK WAKEFIELD</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>LULA MURRAY</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>LUCILLE COWAN (SISTER)</b>  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1990 MEADE STREET DETROIT, MICHIGAN 48212</b>  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MARYLAND NATIONAL CEM. 9/4/96</b>   |  | 20c. Location - City or Town, State<br><b>LAUREL, MARYLAND</b>                   |   |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>ESTEP BROTHERS FUNERAL HOME P.A.<br/>1300 EUTAW PLACE BALTIMORE, MARYLAND 21217</b>  |  |  |  |  |   |  |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>a. Arteriosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):<br><br><b>b.</b> Due to (or as a consequence of):<br><br><b>c.</b> Due to (or as a consequence of):<br><br><b>d.</b> Due to (or as a consequence of): |  |   |  |  |  |  | Approximate Interval Between Onset and Death  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><b>INSPECTION</b>  |  |   |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
|   | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
|   | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                    |  |   |  |  |  |  | 29b. Signature and title of certifier<br>   |  |
|   | 29c. License number<br><b>O.C.M.E.</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>AUGUST 26, 1996</b>   |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201</b>                                    |  |  |   |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>AUG 30 1996</b>  |  | 32. Registrar's Signature<br>   |  |  |  |  |   |  |

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 1, 1861. It is a very important document, as it contains the President's message to Congress at the beginning of his first term.

2. The second part of the document is a letter from the President to the Congress, dated January 1, 1861. It is a very important document, as it contains the President's message to Congress at the beginning of his first term.

3. The third part of the document is a letter from the President to the Congress, dated January 1, 1861. It is a very important document, as it contains the President's message to Congress at the beginning of his first term.

4. The fourth part of the document is a letter from the President to the Congress, dated January 1, 1861. It is a very important document, as it contains the President's message to Congress at the beginning of his first term.

5. The fifth part of the document is a letter from the President to the Congress, dated January 1, 1861. It is a very important document, as it contains the President's message to Congress at the beginning of his first term.

6. The sixth part of the document is a letter from the President to the Congress, dated January 1, 1861. It is a very important document, as it contains the President's message to Congress at the beginning of his first term.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

219-10-3939

State of Maryland / Department of Health and Mental Hygiene

96 25934

## Certificate of Death

Reg. No.

|  |   |  |   |  |   |  |  |   |  |  |
|--|---|--|---|--|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>FRIEDA KILOUFF</b>   |  |   |  |   |  | 2. Date of Death<br>Month <b>August</b> Day <b>28</b> Year <b>96</b>             |   | 3. Time of Death<br><b>4:17pm</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Good Samaritan Hospital</b>  |  |   |  |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>                    |   | 4c. County of Death<br><b>N/A</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>219-10-3939</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Apr 23, 1909</b>                       |   | 9. Birthplace (State or Foreign Country)<br><b>Germany</b>                                     |  |
|  | Usual Residence of Decedent   |  |   |  |   |  |  |   |  |  |
| To Be Completed by Funeral Director                                  | 10a. State<br><b>Md.</b>  |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore City</b>  |  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|  | 10e. Street and Number<br><b>6123 Fairdel Avenue</b>  |  |   |  | 10f. Zip Code<br><b>21206</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>                            |   |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>College</b>  |  |   |  | 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>                       |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>(Not Known) Postelmann</b>  |  |   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Johanna (Not Known)</b>  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Joan K. Hanzlik</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1 Elinor Avenue Baltimore, Maryland 21236</b>   |  |  |   |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parkwood Cemetery</b>  |  | Date<br><b>8/31/96</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore Maryland</b>                 |   |  |  |
|  | 21. Signature of Funeral Service Licensee <b>Milton Knight Jr</b><br><i>Milton Knight Jr</i>  |  |   |  | 22. Name and Address of Facility<br><b>Leonard J. Ruck, Inc.<br/>5305 Harford Road Baltimore, Md. 21214</b>   |  |  |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each link.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Metastatic Breast Carcinoma</b><br>Due to (or as a consequence of):<br>b. <b>Aspiration Pneumoniae</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  |   |  |  |   |  |  |
|  | Approximate Interval Between Onset and Death<br><b>Yrs 4 days</b>   |  |   |  |   |  |  |   |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Atrial Fibrillation, Hypertension</b>  |  |   |  |   |  |  |   |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |   |  |   |  |  |   |  |  |
|  | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |  |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |   |  |  |   |  |  |
|  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |  |   |  |  |   |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)     |   |  |  |
|  | 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |   |  |  |   |  |  |
|  | 29b. Signature and title of certifier<br><b>Lena Sayegh MD</b>  |  |   |  |   | 29c. License number<br><b>POB 239</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>August 28 - 1996</b>          |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Good Samaritan Hospital. 5601 Loch Raven blvd Baltimore Maryland 21239</b>   |  |   |  |   |  |  |   |  |  |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)<br><b>AUG 30 1996</b>   |  |   |  |   | 32. Registrar's Signature<br><i>Johnston-Randall</i>   |  |   |  |  |

Baltimore, Maryland 21215-0020

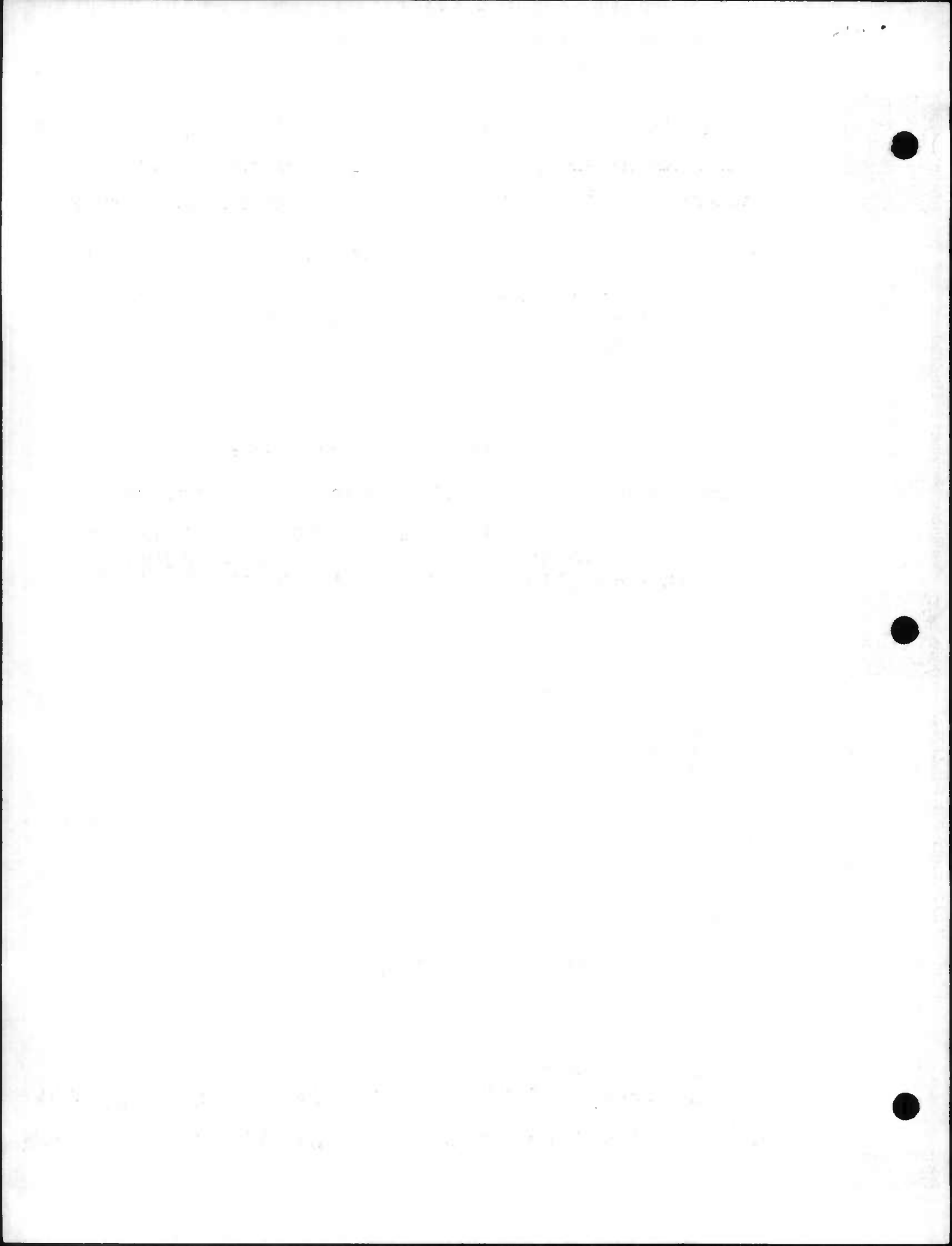
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25935

## Certificate of Death

Reg. No.

|  |   |   |   |                                |  |  |  |  |  |  |   |          |                                  |  |          |                                  |          |                                  |          |
|--|---|---|---|--------------------------------|--|--|--|--|--|--|---|----------|----------------------------------|--|----------|----------------------------------|----------|----------------------------------|----------|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>EVELYN IRENE KIERNER  |   |   |                                | 2. Date of Death<br>Month Day Year<br>AUGUST 28, 1996  |  |  |  | 3. Time of Death<br>8:40 AM  |  |   |          |                                  |  |          |                                  |          |                                  |          |
|  | 4a. Facility Name (If not Institution, give street and number)<br>MERIDIAN NURSING HOME-LOCH RAVEN  |   |   |                                | 4b. City, Town, or Location of Death<br>LOCH RAVEN   |  |  |  | 4c. County of Death<br>BALTIMORE   |  |   |          |                                  |  |          |                                  |          |                                  |          |
| Funeral<br>Director  | 5. Social Security Number<br>215-22-3271  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |                                | 7. Age (In yrs. last birthday)<br>88 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>JULY 30, 1908       |  | 9. Birthplace (State or Foreign Country)<br>BALTIMORE CITY   |  |   |          |                                  |  |          |                                  |          |                                  |          |
|  | Usual Residence of Decedent   |   |   |                                |  |  |  |  |  |  |   |          |                                  |  |          |                                  |          |                                  |          |
| To Be Completed by Funeral Director  | 10a. State<br>MARYLAND  |   | 10b. County<br>BALTIMORE  |                                | 10c. City, Town or Location<br>BALTIMORE COUNTY  |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |   |          |                                  |  |          |                                  |          |                                  |          |
|  | 10e. Street and Number<br>3619 HEATHERS WAY ROAD  |   |   |                                | 10f. Zip Code<br>21234   |  | 10g. Citizen of What Country?<br>U.S.A.                    |  |  |  |   |          |                                  |  |          |                                  |          |                                  |          |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE   |  |  |   |          |                                  |  |          |                                  |          |                                  |          |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+) N/A  |   |   |                                | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>HOUSEWIFE   |  |  | 16b. Kind of Business/Industry<br>HOUSEKEEPING-OWN HOME  |  |  |   |          |                                  |  |          |                                  |          |                                  |          |
|  | 17. Father's Name (First, Middle, Last)<br>GEORGE SCHIRMER  |   |   |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>IRENE NAGENGAST   |  |  |  |  |  |   |          |                                  |  |          |                                  |          |                                  |          |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>DONALD KIEFNER (SON)  |   |   |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3619 HEATHERS WAY ROAD BALTIMORE, MARYLAND 21234  |  |  |  |  |  |   |          |                                  |  |          |                                  |          |                                  |          |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>PARKWOOD CEMETERY   |                                | Date<br>AUGUST 31, 1996  |  | 20c. Location - City or Town, State<br>BALTIMORE, MARYLAND |  |  |  |   |          |                                  |  |          |                                  |          |                                  |          |
|  | 21. Signature of Funeral Service Licensee<br>   |   |   |                                | 22. Name and Address of Facility<br>LASSAHN FUNERAL HOME, INC.<br>7401 BELAIR ROAD BALTIMORE, MARYLAND 21236-4625  |  |  |  |  |  |   |          |                                  |  |          |                                  |          |                                  |          |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |                                |  |  |  |  |  |  |   |          |                                  |  |          |                                  |          |                                  |          |
|  | <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td>a. _____</td> <td>Due to (or as a consequence of):</td> <td rowspan="4">           Approximate Interval Between Onset and Death<br/><br/>           &lt; 2 weeks<br/><br/>           &gt; 5 years         </td> </tr> <tr> <td>b. _____</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c. _____</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d. _____</td> <td>Due to (or as a consequence of):</td> </tr> </table> |   |   |                                |  |  |  |  |  |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. _____ | Due to (or as a consequence of): | Approximate Interval Between Onset and Death<br><br>< 2 weeks<br><br>> 5 years | b. _____ | Due to (or as a consequence of): | c. _____ | Due to (or as a consequence of): | d. _____ |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  | a. _____  | Due to (or as a consequence of):  | Approximate Interval Between Onset and Death<br><br>< 2 weeks<br><br>> 5 years  |                                |  |  |  |  |  |  |   |          |                                  |  |          |                                  |          |                                  |          |
|  | b. _____  | Due to (or as a consequence of):  |   |                                |  |  |  |  |  |  |   |          |                                  |  |          |                                  |          |                                  |          |
|  | c. _____  | Due to (or as a consequence of):  |   |                                |  |  |  |  |  |  |   |          |                                  |  |          |                                  |          |                                  |          |
|  | d. _____  | Due to (or as a consequence of):  |   |                                |  |  |  |  |  |  |   |          |                                  |  |          |                                  |          |                                  |          |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |                                |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |   |          |                                  |  |          |                                  |          |                                  |          |
|  |   |   |   |                                |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   |          |                                  |  |          |                                  |          |                                  |          |
|  |   |   |   |                                |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |          |                                  |  |          |                                  |          |                                  |          |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |                                |  |  |  |  |  |  |   |          |                                  |  |          |                                  |          |                                  |          |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M       |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |  |   |          |                                  |  |          |                                  |          |                                  |          |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |   |   |                                |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |  |  |  |  |   |          |                                  |  |          |                                  |          |                                  |          |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |                                |  |  |  |  |  |  |   |          |                                  |  |          |                                  |          |                                  |          |
| 29b. Signature and title of certifier<br>  |   |   |   | 29c. License number<br>D 32939 |  | 29d. Date signed (Month, Day, Year)<br>8/28/96                                       |  |  |  |  |   |          |                                  |  |          |                                  |          |                                  |          |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Gregory P. Johnson 2114 E. Joppa Road Baltimore, MD 21234  |   |   |   |                                |  |  |  |  |  |  |   |          |                                  |  |          |                                  |          |                                  |          |
| 31. Date filed (Month, Day, Year)<br>AUG 30 1996   |   |   |   | 32. Registrar's Signature<br>  |  |  |  |  |  |  |   |          |                                  |  |          |                                  |          |                                  |          |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
item #19b, filmg 738, 8/30/96, cyw, per fh

96 25936

## Certificate of Death

Reg. No.

|  |  |   |  |  |  |   |  |   |  |                                      |   |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
|--|--|---|--|--|--|---|--|---|--|--------------------------------------|---|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>DONALD KOONCE</b>   |   | 2. Date of Death<br>Month Day Year<br><b>AUGUST 28 1996</b>                                  |  | 3. Time of Death<br><b>2030 P</b>            |   |  |   |  |                                      |   |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>MD RTE# 495 &amp; MD RTE# 210</b>   |   | 4b. City, Town, or Location of Death<br><b>OXON HILL</b>                                     |  | 4c. County of Death<br><b>PRINCE GEORGES</b> |   |  |   |  |                                      |   |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>056-44-1781</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>42</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.               |   |  |   |  |                                      |   |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
|  | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 8, 1953</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>N. Carolina</b>                               |  |  |   |  |   |  |                                      |   |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| Usual Residence of Decedent  |  |   |  |  |  |   |  |   |  |                                      |   |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 10e. State<br><b>NC</b>  |  | 10b. County<br><b>Jones</b>   |  | 10c. City, Town or Location<br><b>Pollocksville</b>  |  |   |  |   |  |                                      |   |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |   |  |   |  |                                      |   |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 10e. Street and Number<br><b>764 Goshen Road</b>   |  | 10f. Zip Code<br><b>28573</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |  |   |  |                                      |   |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   |  |   |  |                                      |   |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |   |  |  |  |   |  |   |  |                                      |   |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Sacondery (0-12) <b>12</b> College (14 or 5+) <b>2</b>   |  | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Truck Driver</b>                  |  | 16b. Kind of Business/Industry<br><b>Delivery</b>  |  |   |  |   |  |                                      |   |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Carl Koonce, Jr.</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lina White</b>  |  |  |  |   |  |   |  |                                      |   |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 19e. Informant's Name/Relationship (Type, Print)<br><b>LaJune Marie Mabry Koonce</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>764 Goshen Road, Pollocksville, NC 28573</b>  |  |  |  |   |  |   |  |                                      |   |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Haiti Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>Trenton, N. Carolina</b>   |  |   |  |   |  |                                      |   |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Heroy O. Dyett</i>   |  | 22. Name and Address of Facility<br><b>LEROY O. DYETT &amp; SON FUNERAL HOME, P.A.<br/>4600 LIBERTY HEIGHTS AVE., BALTO. 21207</b>                |  |  |  |   |  |   |  |                                      |   |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |  |  |   |  |   |  |                                      |   |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           a. <b>Head Injuries</b><br/>           Due to (or as a consequence of):<br/><br/>           b. Due to (or as a consequence of):<br/><br/>           c. Due to (or as a consequence of):<br/><br/>           d. Due to (or as a consequence of):         </td> <td colspan="5">           23b. Did tobacco use contribute to the cause of death?<br/> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown         </td> </tr> <tr> <td colspan="5">           24e. Was an autopsy performed?<br/> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No         </td> </tr> <tr> <td colspan="5">           24b. Were autopsy findings available prior to completion of cause of death?<br/> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No         </td> </tr> <tr> <td colspan="5">           25. Was case referred to medical examiner?<br/> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No         </td> </tr> </table>   |  |   |  |  |  | Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Head Injuries</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |                                      |   | 24e. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No      |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |  |  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Head Injuries</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |  |  |   |  |   |  |                                      |   |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
|  | 24e. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |  |  |   |  |   |  |                                      |   |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
|  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |  |  |   |  |   |  |                                      |   |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
|  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |  |  |   |  |   |  |                                      |   |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |   |  |   |  |                                      |   |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| <table border="0"> <tr> <td colspan="2">26. Place of Death (Check only one)<br/>Hospital: <input type="checkbox"/> inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b></td> </tr> <tr> <td>27. Manner of Death<br/><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br/><input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide</td> <td>28a. Date of Injury (Month, Day, Year)<br/><b>8-28-96</b></td> <td>28b. Time of Injury<br/><b>2005 M</b></td> <td>28c. Injury at Work?<br/><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</td> <td colspan="2">28d. Describe how injury occurred<br/><b>Driver of truck struck by a tire that fell off another vehicle</b></td> </tr> <tr> <td colspan="3">28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)<br/><b>Roadway</b></td> <td colspan="3">28f. Location (Street and Number or Rural Route Number, City or Town, State)<br/><b>I 495</b></td> </tr> </table> |  |   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b> |  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | 28a. Date of Injury (Month, Day, Year)<br><b>8-28-96</b> | 28b. Time of Injury<br><b>2005 M</b> | 28c. Injury at Work?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred<br><b>Driver of truck struck by a tire that fell off another vehicle</b> |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Roadway</b> |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>I 495</b>   |  |  |  |  |   |  |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>  |  |   |  |  |  |   |  |   |  |                                      |   |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  | 28a. Date of Injury (Month, Day, Year)<br><b>8-28-96</b>   | 28b. Time of Injury<br><b>2005 M</b>  | 28c. Injury at Work?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  | 28d. Describe how injury occurred<br><b>Driver of truck struck by a tire that fell off another vehicle</b>   |  |   |  |   |  |                                      |   |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Roadway</b>   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>I 495</b> |  |  |   |  |   |  |                                      |   |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |   |  |   |  |                                      |   |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>  |  | 29c. License number<br><b>O.C.M.E</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>AUGUST 29, 1996</b>  |  |   |  |   |  |                                      |   |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>   |  |   |  |  |  |   |  |   |  |                                      |   |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 30 1996</b>  |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |  |   |  |   |  |                                      |   |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 25937

Reg. No.

|   |   |  |   |  |  |  |  |   |
|---|---|--|---|--|--|--|--|---|
| Physician<br>/Medical<br>Examiner                       | 1. Decedent's Name (First, Middle, Last)<br><b>Mary Ellen Knachel</b>   |  |   |  | 2. Date of Death<br>Month <b>Aug</b> Day <b>20</b> Year <b>1996</b>  |  | 3. Time of Death<br><b>12:26pm</b>   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>202 Stevens Rd</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Middle River</b>  |  | 4c. County of Death<br><b>Baltimore</b>  |   |
| Funeral<br>Director                                     | 5. Social Security Number<br><b>218-01-2263</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>Month <b>Nov</b> Day <b>13</b> Year <b>1915</b>  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
|   | Usual Residence of Decedent   |  |   |  |  |  |  |   |
| To Be Completed by Funeral Director                     | 10a. State<br><b>Md.</b>  | 10b. County<br><b>Baltimore</b>                            | 10c. City, Town or Location<br><b>Middle River</b>  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |
|   | 10e. Street and Number<br><b>202 Stevens Road</b>   |  |   | 10f. Zip Code<br><b>21220</b>                    |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>   |  | 16b. Kind of Business/Industry<br><b>own home</b>  |  |  |   |
| To Be Completed by Physician/Medical Examiner           | 17. Father's Name (First, Middle, Last)<br><b>George McNelly</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rose Finn</b>  |  |  |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Lawrence Knachel Jr./ son</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>25 Dogwood Drive Baltimore Md. 21220</b>   |  |  |   |
|   | 20e. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gardens of Faith</b>   |  | Date<br><b>8/23/96</b>   | 20c. Location - City or Town, State<br><b>Rossville Md.</b>                                    |  |   |
|   | 21. Signature of Funeral Service Licensee<br><b>R. Terry Connolly</b>   |  |   |  | 22. Name and Address of Facility<br><b>Connolly Funeral Home of Essex<br/>300 Mace Ave. Baltimore Md. 21221</b>  |  |  |   |
| Physician<br>/Medical<br>Examiner                       | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Cardiac Arrest</b><br>Due to (or as a consequence of):<br><b>Myocardial Infarction</b><br>Due to (or as a consequence of):<br><b>Coronary Insufficiency</b><br>Due to (or as a consequence of):<br><b>Diabetes Mellitus</b> |  |   |  |  |  | Approximate Interval Between Onset and Death<br><b>Same Day</b><br><b>Same Day</b><br><b>Several Yrs.</b><br><b>Several Yrs.</b>                   |   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |  |   |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |
|   |   |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
| To Be Completed by Physician/Medical Examiner           | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |   |
|   | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |
|   |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                   |  |   |  |  |  |  |   |
| State Registrar   | 29b. Signature and title of certifier<br><b>J. Jay Platt</b>  |  |   |  | 29c. License number<br><b>209516</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>8/29/96</b>  |   |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>J. Jay Platt MD 2809 Boston St. Ste 1 Balto MD 21224</b>   |  |   |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>AUG 30 1996</b> |   | 32. Registrar's Signature<br><b>J. A. Davidson-Randall</b> |   |  |  |  |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

96 25938

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HENRY ELLSWORTH LEHR

2. Date of Death

Month August Day 28, 1996 Year

3. Time of Death

12:15P

4a. Facility Name (If not institution, give street and number)

6 Candlelight Court

4b. City, Town, or Location of Death

Lutherville

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

161-20-4577

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
December 14, 1927

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Lutherville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6 Candlelight Court

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sales Manager

16b. Kind of Business/Industry

Chemical Manufacturing

17. Father's Name (First, Middle, Last)

Curvin Ellsworth Lehr

18. Mother's Name (First, Middle, Maiden Surname)

Rebecca Julius

19a. Informant's Name/Relationship (Type, Print)

Mrs. C. Lehr

Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6 Candlelight Court Lutherville, Maryland 21093

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenmount Cemetery

Date

8/29/96

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Dennis Stephen Kenakis

22. Name and Address of Facility

Mitchell-Wiedefeld Home

6500 York Road Baltimore, Maryland 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

LUNG CANCER

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

G. I. U.

29c. License number

D 27730

29d. Date signed (Month, Day, Year)

August 29, 1996

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Gary I Cohen 6569 North Charles Street Towson, Maryland 21204 Suite 205

31. Date filed (Month, Day, Year)

AUG 30 1996

32. Registrar's Signature

Gina Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25939

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |   |  |   |  |
|---|---|--|---|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>MARY L. LAUTING</b>  |  |   |  |  |  | 2. Date of Death<br>Month Day Year<br><b>August 26, 1996</b>  |  | 3. Time of Death<br><b>10:45 A.M.</b>                       |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Charlestown Retirement Community Lane Catonsville</b>  |  |   |  |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  | 4c. County of Death<br><b>Baltimore</b>                     |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>215-10-6308</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>89</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Sept 19, 1906</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |  |
|   | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Catonsville</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |
| To Be Completed by Funeral Director   | 10e. Street and Number<br><b>711 Maiden Choice Lane</b>   |  |   |  | 10f. Zip Code<br><b>21228</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 years</b> College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Buyer - Silverware Dept.</b>   |  | 16b. Kind of Business/Industry<br><b>Hutzlers Department Store</b>  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>John Lipscomb</b>   |  |   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Catherine Wright</b>  |  |   |  |
| Physician<br>/Medical<br>Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Jean Gralewicz (Niece)</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3647 Campfield Rd. Baltimore, MD 21207</b>   |  |   |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Glen Haven Memorial Park</b>  |  | 20c. Location - City or Town, State<br><b>8-26-96 Glen Burnie, MD</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner   | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |  |   |  | 22. Name and Address of Facility<br><b>Loring Byers Funeral Directors, Inc.<br/>8728 Liberty Rd. Randallstown, MD 21133</b>  |  |   |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>SEPSIS</b><br>Due to (or as a consequence of):<br><b>URINARY TRACT INFECTION</b><br>Due to (or as a consequence of):<br><b>MALNUTRITION</b><br>Due to (or as a consequence of):<br><b>DEMENTIA</b>        |  |   |  | Approximate Interval Between Onset and Death<br><b>6 DAYS</b><br><b>2 WEEKS</b><br><b>2 MONTHS</b><br><b>YEARS</b>   |  |   |  |   |  |
| Division of Vital Records, P.O. Box 68760,<br>Baltimore, Maryland 21215-0020  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |  |
|   |   |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred                           |  |
| State Registrar   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><i>[Signature]</i>   |  | 29c. License number<br><b>044748</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>August 26, 1996</b>   |  |   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Matthew Narrett, M.D. 711 Maiden Choice Lane Catonsville, MD 21228</b>   |  |   |  |  |  |   |  |   |  |
| DHMH 16 Rev 6/95  | 31. Date filed (Month, Day, Year)<br><b>AUG 30 1996</b>   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |  |   |  |   |  |



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State of Maryland / Department of Health and Mental Hygiene

96 25940

## Certificate of Death

Reg. No.

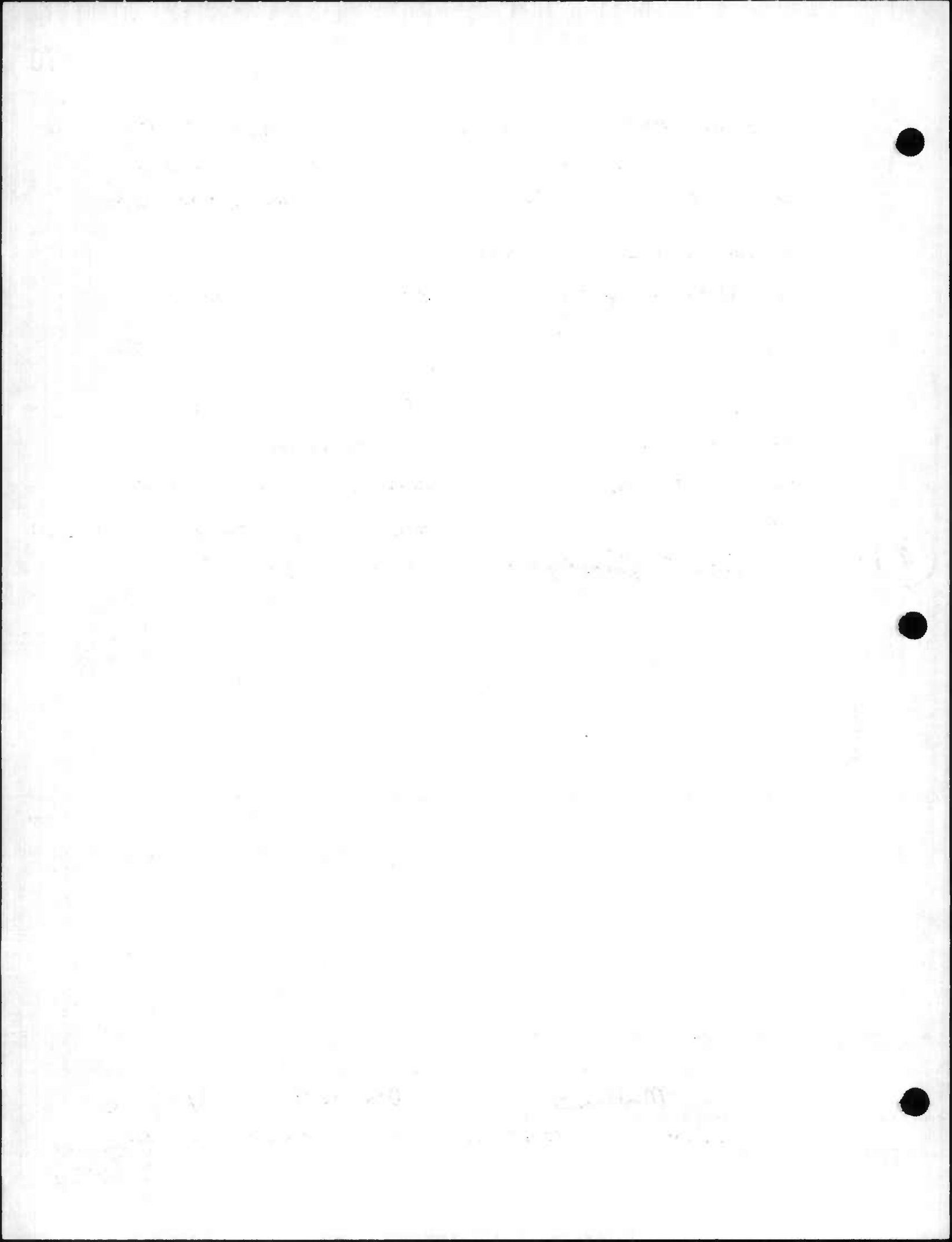
|  |  |   |   |   |  |   |  |   |  |
|--|--|---|---|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Thelma Juanita MCCOMBS</b>  |   |   |   | 2. Date of Death<br>Month <b>August</b> Day <b>30</b> Year <b>1996</b>   |   | 3. Time of Death<br><b>4:00 am</b>   |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Franklin Square Hospital</b>  |   |   |   | 4b. City, Town, or Location of Death<br><b>Rossville</b>   |   | 4c. County of Death<br><b>Baltimore</b>  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>227-09-9612</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.  | If Under 1 Year<br>Months Days                        | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 2, 1910</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>   |  |
|  | Usual Residence of Decedent  |   |   |   |  |   |  |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Baltimore</b>   |   | 10c. City, Town or Location<br><b>Dundalk</b>  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |
|  | 10e. Street and Number<br><b>7412 Old Battle Grove Rd.</b>   |   |   |   | 10f. Zip Code<br><b>21222</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b>  |   | Collage (1-4 or 5+) <b></b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>House Wife</b>   |   | 16b. Kind of Business/Industry<br><b>Own Home</b>  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Frederick L. Gough</b>   |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sallie Mooney</b>  |   |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Glen Young (nephew)</b>   |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>203 North Stuart St. Baltimore, Md. 21221</b>  |   |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gardens Of Faith Mem.</b>  |   | Data<br><b>9/3/1996</b>  |   | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>  |   |  |
|  | 21. Signature of Funeral Service Licensee<br>  |   |   |   | 22. Name and Address of Facility<br><b>Bruzdzinski Funeral Home P.A.<br/>1407 Old Eastern Ave. Essex, Md. 21221</b>  |   |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Renal Failure</b><br>Dua to (or as a consequence of):<br><b>b. Aortic Stenosis</b><br>Dua to (or as a consequence of):<br><b>c.</b><br>Dua to (or as a consequence of):<br><b>d.</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |   |  |   |  |   | Approximate Interval Between Onset and Death<br><b>48 hours</b><br><b>48 hours</b> |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |
|  |  |   |   |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>                       |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                      |  | 28d. Describe how injury occurred   |  |
|  |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                          |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>   |   |   |  |   |  |   |  |
|  |  | 29c. License number<br><b>DS0164</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>8/30/96</b> |  |   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Liji Mathew 9000 Franklin Square Drive Baltimore, MD 21237</b>  |  |   |   |   |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 30 1996</b>  |  | 32. Registrar's Signature<br>   |   |   |  |   |  |   |  |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerDivision of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



96 25941

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Frederick Miller, Sr.</i>  |  |   |  | 2. DATE OF DEATH<br>MONTH <i>August</i> DAY <i>20</i> YEAR <i>1996</i>  |  |   |  | 3. TIME OF DEATH<br><i>6:36 P.M.</i>   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>234-01-9337</i>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><i>84</i> YRS.  |  | 7. DATE OF BIRTH<br>MONTH <i>Oct.</i> DAY <i>12</i> YEAR <i>1911</i>                        |  | 8. BIRTHPLACE (State or Foreign Country)<br><i>WEST VIRGINIA</i>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>WASHINGTON ADVENTIST HOSPITAL</i>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>TAKOMA PARK</i>   |  |   |  | 9c. COUNTY OF DEATH<br><i>MONTGOMERY</i>   |  |
| RESIDENCE OF DECEDENT  |  |   |  |   |  |   |  |  |  |
| 10a. STATE<br><i>MARYLAND</i>  |  | 10b. COUNTY<br><i>PRINCE GEORGES</i>  |  | 10c. CITY, TOWN OR LOCATION<br><i>HYATTSVILLE</i>   |  |   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><i>6118 42ND AVENUE</i>  |  |   |  | 10f. ZIP CODE<br><i>20781</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U. S. A.</i>  |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><i>WWII</i> |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <i>XX</i> |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>WHITE</i>                     |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>8</i> College (1-4 or 5+) <i></i>   |  |   |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>PAINTER</i>   |  | 15b. KIND OF BUSINESS/INDUSTRY<br><i>CONSTRUCTION</i>                                       |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>R. D. MILLER</i>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>ALPHA MILLER</i>  |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>CAROLYN PALMER MILLER</i>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>10814 RIVER OAK TERRACE, MITCHELLVILLE, MD 20721</i>  |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i></i>  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place)<br><i>ROSEDALE CEMETERY</i>  |  | DATE<br><i>8/25</i>   |  | 20c. LOCATION — City or Town, State<br><i>MARTINSBURG, WV</i>                               |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Charles M. Brown</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><i>BROWN FUNERAL HOME, 327 W. KING STREET<br/>PO BOX 821, MARTINSBURG, WV 25401</i>   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Chronic Obstructive Lung Disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. <i></i> |  |   |  |   |  |   |  | Approximate interval Between Onset and Death<br><i>years</i>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>  |  |   |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |   |  |   |  | 28. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <i></i> |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><i>N/A</i>  |  | 28b. TIME OF INJURY<br><i>M</i>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><i></i>   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><i></i>  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><i></i>   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Paul A. DeVore, MD</i>   |  |   |  | 29c. LICENSE NUMBER<br><i>D01852</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>AUGUST 21, 1996</i>                               |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>PAUL A. DEVORE, MD 4203 QUEENSBURY Rd Hyattsville MD 20781</i>   |  |   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><i>AUG 30 1996</i>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the paper

is devoted to the

study of the properties of the

operator  $T$  defined by

the formula  $Tf(x) = \int_0^x f(t) dt$ . It is shown that  $T$  is a bounded operator on  $L^p$  for  $1 < p < \infty$  and that its norm is equal to 1. The second part of the paper is devoted to the study of the operator  $T$  on  $L^1$  and  $L^\infty$ . It is shown that  $T$  is not bounded on  $L^1$  and  $L^\infty$ .



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25942

## Certificate of Death

Reg. No.

|   |  |  |   |  |   |                                  |  |  |
|---|--|--|---|--|---|----------------------------------|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>MELVIN GEORGE MOHR   |  |   | 2. Date of Death<br>Month Day Year<br>AUGUST 28 1996 |   | 3. Time of Death<br>11:15 AM     |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>9000 PHILADELPHIA ROAD   |  |   | 4b. City, Town, or Location of Death<br>WHITE MARSH  |   | 4c. County of Death<br>BALTIMORE |  |  |
| Funeral<br>Director                           | 5. Social Security Number<br>213-01-3597   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>79 Yrs.   |                                  | 8. Date of Birth (Month, Day, Year)<br>JUNE 11, 1917   |  |
|   | 9. Birthplace (State or Foreign Country)<br>BALTIMORE CO., MD.   |  | 10a. State<br>MARYLAND  |  | 10b. County<br>BALTIMORE  |                                  | 10c. City, Town or Location<br>BALTIMORE COUNTY  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br>9000 PHILADELPHIA ROAD  |  | 10f. Zip Code<br>21237  |                                  | 10g. Citizen of What Country?<br>U.S.A.  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Navar Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |                                  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE   |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 5 Collage (1-4or 5+) N/A  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>EQUIPMENT OPERATOR   |  | 16b. Kind of Business/Industry<br>BALTIMORE BRICK COMPANY   |                                  | 17. Father's Name (First, Middle, Last)<br>GEORGE MOHR   |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br>SOPHIA WEINREICH  |  | 19a. Informant's Name/Relationship (Type, Print)<br>WAYNE HESS  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>16835 FALLS ROAD UPPERCOO, MARYLAND 21155  |                                  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |
| Physician<br>/Medical<br>Examiner             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>PARKWOOD CEMETERY  |  | 20c. Date<br>AUGUST 31, 1996  |  | 20d. Location - City or Town, State<br>BALTIMORE, MARYLAND  |                                  | 21. Signature of Funeral Service Licensee<br>[Signature]   |  |
|   | 22. Name and Address of Facility<br>LASSAHN FUNERAL HOME, INC.<br>7401 BELAIR ROAD BALTIMORE, MARYLAND 21236-4625  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>a. Intracranial shotgun wound<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |                                  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                 |  | 25. Was case referred to medical examiner?<br>XX Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home XX Residence 6 <input type="checkbox"/> Other (Specify)  |                                  | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  |
|   | 28a. Date of Injury (Month, Day, Year)<br>8-28-96  |  | 28b. Time of Injury<br>0850 M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |                                  | 28d. Describe how injury occurred<br>subject shot self   |  |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>Residence  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>9000 Old Philadelphia Rd  |  | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>XX <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                  | 29b. Signature and title of certifier<br>[Signature]   |  |
|   | 29c. License number<br>O.C.M.E.  |  | 29d. Date signed (Month, Day, Year)<br>AUGUST 29, 1996  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>David R Fowler 111 Penn Street, Baltimore, Maryland 21201   |                                  | 31. Date filed (Month, Day, Year)<br>AUG 30 1996   |  |
| 32. Registrar's Signature<br>[Signature]      |  |  |   |  |   |                                  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

6/27

2/12/12

7/27/12

2/12/12

2/12/12

2/12/12

2/12/12

2/12/12

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Talmadge McKissick</b>   |  |   |  | 2. Date of Death<br>Month <b>08</b> Day <b>16</b> Year <b>96</b>   |  | 3. Time of Death<br><b>10:31</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Prince Georges Hospital Center</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Cheverly, MD</b>  |  | 4c. County of Death<br><b>Princes Georges</b>  |  |
| 5. Social Security Number<br><b>578 06 1897</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>29</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>7 18 67</b>  |  |
| Usuel Residence of Decedent   |  | 9. Birthplace (State or Foreign Country)<br><b>WASHINGTON, DC</b>   |  |  |  |  |  |
| 10a. State<br><b>DC</b>   |  | 10b. County<br><b>WASHINGTON</b>  |  | 10c. City, Town or Location<br><b>WASHINGTON</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>3911 1st ST. SE</b>  |  |   |  | 10f. Zip Code<br><b>20032</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>                     |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> Collage (14 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CARPENTER INSTALLER</b>  |  | 16b. Kind of Business/Industry<br><b>PRIVATE INDUSTRY</b>                                      |  |
| 17. Father's Name (First, Middle, Last)<br><b>HAROLD McDOWELL</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ELNORA SMITH MCKISSICK</b>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>DEBORAH MCKISSICK</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>133 RHODE ISLAND AVE NE WASHINGTON, DC 20002</b>   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>HARMONY MEMORIAL CEMETERY 8/24/96 LANDOVER, MD</b>                   |  | 20c. Location - City or Town, State  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Robert G. Mason</i>   |  |   |  | 22. Name and Address of Facility<br><b>ROBERT G. MASON FUNERAL HOME<br/>1661 GOOD HOPE RD. SE WASHINGTON, DC 20020</b>   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediata Causa (Final disease or condition resulting in death)<br>a. <b>Gun shot wound to chest</b><br>Due to (or as a consequence of):<br><br>b. _____<br>Due to (or as a consequence of):<br><br>c. _____<br>Due to (or as a consequence of):<br><br>d. _____<br><br>Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |  |  |  |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input checked="" type="checkbox"/> Homicidal<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)<br><b>8-16-96</b>  |  | 28b. Time of Injury<br><b>2:56</b> M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  |
|   |  | 28d. Describe how injury occurred<br><b>subject shot</b>  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>3916 South Capital St SE D.C.</b>   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                   |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |  |  |
| 29b. Signature and Title of Certifier<br><i>[Signature]</i>   |  |   |  | 29c. License number<br><b>O.C.M.E</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>August 16, 1996</b>                                  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>  |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 30 1996</b>   |  |   |  | 32. Registrar's Signature<br><i>[Signature]</i>  |  |  |  |

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25944

## Certificate of Death

Reg. No.

|  |   |   |  |   |   |  |  |   |
|--|---|---|--|---|---|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>David M. Middleton</b>                                   |   |  |   | 2. Date of Death<br>Month <b>8</b> Day <b>25</b> Year <b>96</b> |  | 3. Time of Death<br><b>7 AM</b>  |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Hyattsville Health CARE Center</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Hyattsville</b>      |  | 4c. County of Death<br><b>Prince George</b>  |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>226-94-7479</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>30</b> Yrs.  | If Under 1 Year<br>Months Days                                  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>07 29 66</b>   | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>   |
|  | Usual Residence of Decedent   |   |  |   |   |  |  |   |
| 10a. State<br><b>Virginia</b>  |   | 10b. County<br><b>ARLington</b>   |  | 10c. City, Town or Location   |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
| 10e. Street and Number<br><b>1825 N. Columbus Street</b>   |   |   |  | 10f. Zip Code<br><b>22207</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>                                  |  |   |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+)  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CLerk</b>   |   |  | 16b. Kind of Business/Industry<br><b>Telemarketing</b>   |   |
| 17. Father's Name (First, Middle, Last)<br><b>Carl Middleton</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret McCormick</b>  |   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Jalorce Clark - Aunt</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1825 N. Columbus ST. ARLington, Va. 22207</b>   |   |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Pleasant Valley Memorial PK</b>  |   |  | 20c. Location - City or Town, State<br><b>Annandale, Va.</b>                                   |   |
| 21. Signature of Funeral Service Licensee<br><b>Robert B. Asakura</b>  |   |   |  | 22. Name and Address of Facility<br><b>CHINN Funeral Service<br/>2605 So. Shirlington Rd. ARL., Va.</b>   |   |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |  |   |   |  |  | Approximate Interval Between Onset and Death  |
| Immediate Cause (Final disease or condition resulting in death)<br><b>a. Aids</b><br>Due to (or as a consequence of):<br><b>b. Renal Disease</b><br>Due to (or as a consequence of):<br><b>c. Pancytopenia</b><br>Due to (or as a consequence of):<br><b>d. Cardiopulmonary Failure</b>  |   |   |  |   |   |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b><br><b>Cardiomyopathy</b>   |   |   |  |   |   |  |  |   |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |   |  |   |   |  |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  | 26. Piece of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   |   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |
|  |   |   |  | 28d. Describe how Injury occurred   |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State) |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |  |   |   |  |  |   |
| 29b. Signature and title of certifier<br><b>Robert D. Skipworth MD</b>   |   |   |  | 29c. License number<br><b>D 28906</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>August 29, 1996</b>                |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Robert D. Skipworth MD; 585 main Street, Laurel, Md 20707</b>   |   |   |  |   |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>AUG 30 1996</b>  |   |   |  | 32. Registrar's Signature<br><b>Wilson-Randall</b>  |   |  |  |   |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25945

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

DONALD B. OLIVER JR.

2. Date of Death

August 29 1996

3. Time of Death

1:05 AM

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

340-14-6274

6. Sex

15M 20F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 24, 1922

9. Birthplace (State or Foreign Country)

Illinois

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Odenton

10d. Inside City Limits

10 Yes 20 No

10e. Street and Number

545 Higgins Drive

10f. Zip Code

21113

10g. Citizen of What Country?

USA

11. Marital Status

10 Never Married 20 Married

30 Widowed 40 Divorced

12. Was Decedent Ever in U.S.

10 Yes 20 No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

10 Yes 20 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Lieutenant Colonel

16b. Kind of Business/Industry

US Army

17. Father's Name (First, Middle, Last)

Donald B. Oliver

18. Mother's Name (First, Middle, Maiden Surname)

Ruth K. Keig

19a. Informant's Name/Relationship (Type, Print)

Janice K. Oliver

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

545 Higgins Drive, Odenton, MD 21113

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State

40 Donation 50 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Data

8/30

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Hardesty Funeral Home, P.A.

12 Ridgely Ave. Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

LUNG CANCER

Approximate Interval Between Onset and Death

3 MONTHS

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy performed?

10 Yes 20 No

24b. Were autopsy findings available prior to completion of cause of death?

10 Yes 20 No

25. Was case referred to medical examiner?

10 Yes 20 No

Hospital:

10 Inpatient 20 ER/Outpatient 30 DOA

28. Place of Death (Check only one)

Other: 40 Nursing Home 50 Residence 60 Other (Specify)

27. Manner of Death

10 Natural 50 Pending Investigation  
20 Accident 60 Could not be determined  
30 Suicide  
40 Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

10 Yes 20 No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

10 Certifying Physician

20 Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] Enser W. Cole MD

29c. License number

D16354

29d. Date signed (Month, Day, Year)

August 29 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Enser W. Cole MD 9001 Westgate Rd Annapolis MD 21401

31. Date filed (Month, Day, Year)

AUG 30 1996

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

20





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25946

item #1, filing 738, 8/30/96, cyw, per doctor

Certificate of Death

Reg. No.

|  |   |   |   |  |  |  |  |  |  |   |
|--|---|---|---|--|--|--|--|--|--|---|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br>JOHN L. PALMER JR.  |   |   |  | 2. Date of Death<br>Month Day Year<br>AUGUST 24 1996   |  |  |  | 3. Time of Death<br>8:14 am  |   |
|  | 4e. Facility Name (If not institution, give street and number)<br>THE JOHNS HOPKINS HOSPITAL  |   |   |  | 4b. City, Town, or Location of Death<br>BALTIMORE CITY   |  |  |  | 4c. County of Death<br>N/A   |   |
| Funeral<br>Director  | 5. Social Security Number<br>143-20-8837  |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>68 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Nov. 11, 1927                                 |  | 9. Birthplace (State or Foreign Country)<br>New York   |   |
|  | Usual Residence of Decedent   |   |   |  |  |  |  |  |  |   |
| To Be Completed by Funeral Director                                  | 10a. State<br>Maryland  |   | 10b. County<br>Baltimore  |  | 10c. City, Town or Location<br>Baltimore   |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |
|  | 10e. Street and Number<br>2 C. Durban Ct.   |   |   |  | 10f. Zip Code<br>21236   |  | 10g. Citizen of What Country?<br>U.S.A.  |  |  |   |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12th grade<br>Collega (1-4or 5+)   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Pastor  |  |  | 16b. Kind of Business/Industry<br>Church                         |  |   |
|  | 17. Father's Name (First, Middle, Last)<br>John L. Palmer, Sr.  |   |   |  | 18. Mother's Name (First, Middle, Maiden Sumama)<br>Ann Williams   |  |  |  |  |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Roberta W. Palmer (wife)  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2 C. Durban Ct., Baltimore, MD 21236  |  |  |  |  |   |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Gardens of Faith Cem.   |  | Date<br>8/26/96  |  | 20c. Location - City or Town, State<br>Baltimore, MD.                                |  |  |   |
|  | 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br>Schimunek Funeral Homes, Inc.<br>9705 Belair Rd., Baltimore, MD 21236  |  |  |  |  |   |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |  |  |  |  |  |  |   |
|  | Physician<br>/Medical<br>Examiner   | Immediate Cause (Final disease or condition resulting in death)<br>a. Glioblastoma Multiforme, recurrence<br>Due to (or as a consequence of): |   |  |  |  |  |  |  | Approximate interval Between Onset and Death<br>10 days |
| b. Due to (or as a consequence of):                                  |   |   |   |  |  |  |  |  |  |   |
| c. Due to (or as a consequence of):                                  |   |   |   |  |  |  |  |  |  |   |
| d. Due to (or as a consequence of):                                  |   |   |   |  |  |  |  |  |  |   |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Deep Venous Thromboses<br>Hemophilus Influenza Bronchitis   |   |   |  |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |   |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |  |  |  |   |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |   |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury et Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |   |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |   |
|  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |  |  |  |  |  |  |   |
|  | 29b. Signature and title of certifier<br>   |   |   |  | 29c. License number<br>N9183   |  | 29d. Date signed (Month, Day, Year)<br>08/24/96                                      |  |  |   |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>MELANIE KATZMAN Johns Hopkins Hospital 600 N Wolfe St.  |   |   |  |  |  |  |  |  |   |
|  | 31. Date filed (Month, Day, Year)<br>AUG 30 1996  |   | 32. Registrar's Signature<br>   |  |  |  |  |  |  |   |

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25947

## Certificate of Death

Reg. No.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>DOROTHY MARY PAZDERSKY   |   | 2. Date of Death<br>Month Day Year<br>August 29 1996   |   | 3. Time of Death<br>6:00 AM  |
|   | 4a. Facility Name (If not institution, give street and number)<br>GOOD SAMARITAN HOSPITAL  |   | 4b. City, Town, or Location of Death<br>BALTIMORE  |   | 4c. County of Death<br>BALTIMORE CITY  |
| Funeral<br>Director                           | 5. Social Security Number<br>219-07-0330   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>75   | 8. Data of Birth (Month, Day, Year)<br>MARCH 15, 1921 | 9. Birthplace (State or Foreign Country)<br>BALTIMORE CITY, MD.                                    |
|   | Usual Residence of Decedent  |   |  |   |  |
| To Be Completed by Funeral Director           | 10a. State<br>MARYLAND   | 10b. County<br>BALTIMORE CITY   | 10c. City, Town or Location<br>BALTIMORE   |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|   | 10e. Street and Number<br>5419 HILLEN ROAD   |   | 10f. Zip Code<br>21239   | 10g. Citizen of What Country?<br>U.S.A.               |  |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE                                   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) N/A  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>HOUSEWIFE   |   | 16b. Kind of Business/Industry<br>HOUSEKEEPING-OWN HOME  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br>JOHN HINTENACH  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>M. ELIZABETH FINK   |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>EDWARD J. PAZDERSKY (HUSBAND)  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5419 HILLEN ROAD BALTIMORE, MARYLAND 21239  |   |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>DULANEY VALLEY MEM. GDSNS. AUGUST 31, 1996   |   | 20c. Location - City or Town, State<br>TIMONIUM, MARYLAND  |
|   | 21. Signature of Funeral Service Licensee<br>[Signature]   |   | 22. Name and Address of Facility<br>LASSAHN FUNERAL HOME, INC.<br>7401 BELAIR ROAD BALTIMORE, MARYLAND 21236-4625  |   |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. SEPSIS<br>Due to (or as a consequence of):<br>b. NEUTROPENIA<br>Due to (or as a consequence of):<br>c. ADVANCED OVARIAN CARCINOMA ON CHEMOTHERAPY<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br>4<br>2 YEARS |   |  |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |   |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)<br>28b. Time of Injury<br>M<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>28d. Describe how injury occurred<br>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |  |   |  |
|   | 29b. Signature and title of certifier<br>Anne Owsen MD   |   | 29c. License number<br>P09303  |   | 29d. Date signed (Month, Day, Year)<br>AUGUST 29 1996  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>ANNE OWSEN, GOOD SAMARITAN HOSPITAL, 5601 LOCH RAVEN BLVD. BALTIMORE MD 21239  |   |  |   |  |
|   | 31. Date filed (Month, Day, Year)<br>AUG 30 1996   |   |  |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25948

## Certificate of Death

Reg. No.

|   |  |  |  |  |   |  |   |  |
|---|--|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>JAMES W. RANKIN</b>   |  |  |  | 2. Date of Death<br>Month Day Year<br><b>AUGUST 27 1996</b>   |  | 3. Time of Death<br><b>4:05 P</b>                                       |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Mercy Hospital Stella Maris</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Balto</b>  |  | 4c. County of Death<br><b>NIA</b>                                       |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>165-12-8294</b>  |  | 6. Sex<br><b>1 M 2 F</b>   |  | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>APR 17-28</b>                 |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>N.C.</b>  |  | 10a. State<br><b>md</b>  |  | 10b. County<br><b>NIA</b>   |  | 10c. City, Town or Location<br><b>Balto</b>                             |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><b>X</b> Yes <b>2</b> No  |  | 10e. Street and Number<br><b>2530 W. Lanvale st</b>  |  | 10f. Zip Code<br><b>21216</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A</b>                           |  |
|   | 11. Marital Status<br><b>2 X</b> Married<br><b>3</b> Widowed <b>4</b> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>2 X</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates: <b>WWII</b>           |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br><b>8</b> Elementary/Secondary (0-12)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Mail Clerk</b> |  | 16b. Kind of Business/Industry<br><b>Post office</b>  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>EMANUS RANKIN</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ransy Viola Steadman</b>   |  |   |  |   |  |
| Physician<br>/Medical<br>Examiner             | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary E. Rankin- wife</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2530 W. Lanvale st</b>     |  |   |  |   |  |
|   | 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Balto National Cem.</b>                           |  | 20c. Date<br><b>8/30/96</b>   |  | 20d. Location - City or Town, State<br><b>Balto, md</b>                 |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><b>Shannon Stokes</b>   |  | 22. Name and Address of Facility<br><b>Marth F.H. West<br/>4300 Wabash Ave</b>   |  |   |  |   |  |
|   | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Squamous cell Lung Cancer</b>  |  | Approximate interval between Onset and Death<br><b>1 year</b>  |  |   |  |   |  |
| To Be Completed by Physician/Medical Examiner | Immediate Cause (Final disease or condition resulting in death)<br><b>Squamous cell Lung Cancer</b>  |  | Due to (or as a consequence of):   |  |   |  |   |  |
|   | Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Squamous cell Lung Cancer</b>  |  | Due to (or as a consequence of):   |  |   |  |   |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b>  |  | 23b. Did tobacco use contribute to the cause of death?<br><b>1 X</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown        |  |   |  |   |  |
|   | 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2 X</b> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No                        |  |   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2 X</b> No   |  | 26. Place of Death (Check only one) <b>STELLA MARIS AT MERCY</b>   |  |   |  |   |  |
|   | 27. Manner of Death<br><b>1 X</b> Natural <b>5</b> Pending Investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide   |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No                        |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
|   | 29a. Certifier (Check only one)<br><b>2 X</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>Dr. [Signature]</b>  |  | 29c. License number<br><b>D40480</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>Aug. 28, 1996</b>             |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>FERNANDO J. FERRO, MD</b>   |  | 31. Date filed (Month, Day, Year)<br><b>AUG 30 1996</b>  |  |   |  |   |  |
|   | 32. Registrar's Signature<br><b>[Signature]</b>  |  | 33. Date of Death (Month, Day, Year)<br><b>AUG 27 1996</b>   |  |   |  |   |  |



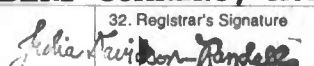
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State of Maryland / Department of Health and Mental Hygiene

96 25949

Certificate of Death

Reg. No.

|  |  |   |  |   |  |  |  |  |
|--|--|---|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>JOAN W SPATES</b>                                     |   |  |   | 2. Date of Death<br>Month <b>AUGUST</b> Day <b>29</b> Year <b>1996</b> |  | 3. Time of Death<br><b>4:30 AM</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>SAINT JOSEPH MEDICAL CENTER</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>TOWSON, MARYLAND</b>        |  | 4c. County of Death<br><b>BALTIMORE</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>705-09-8271</b>  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 16, 1910</b>                         |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |
|  | Usual Residence of Decedent  |   |  |   |  |  |  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Baltimore Co.</b>   |  | 10c. City, Town or Location<br><b>Lutherville</b>   |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>62 Belmore Road</b>   |  |   |  | 10f. Zip Code<br><b>21093</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>                                |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                            |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Home Maker</b>  |  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Unknown</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Unknown</b>   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. David Kenmore Spates (Husband)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>62 Belmore Road Lutherville, Maryland 21093</b>   |  |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hilltop Service Corp.</b>  |  | Date<br><b>8/31/96</b>  |  | 20c. Location - City or Town, State<br><b>Towson, Maryland</b>                       |  |  |
| 21. Signature of Funeral Service Licensee<br> <b>Jeffrey L. Gair</b>   |  |   |  | 22. Name and Address of Facility<br><b>Ruck Towson Funeral Home, Inc.<br/>1050 York Road Towson, Maryland 21204</b>   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |   |  |  |  | Approximate interval Between Onset and Death   |
| Immediate Cause (Final disease or condition resulting in death)<br><b>a. CONGESTIVE HEART FAILURE</b><br>Due to (or as a consequence of):  |  |   |  |   |  |  |  | <b>10 YEARS</b>  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b.</b><br>Due to (or as a consequence of):  |  |   |  |   |  |  |  |  |
| <b>c.</b><br>Due to (or as a consequence of):  |  |   |  |   |  |  |  |  |
| <b>d.</b><br>Due to (or as a consequence of):  |  |   |  |   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CORONARY ARTERY DISEASE</b><br><b>HYPERTENSION</b>  |  |   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
|  |  |   |  |   |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |
|  |  |   |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |  |  |  |
| 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br><b>D 46673</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>AUGUST 29, 1996</b>                        |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ANTHONY HERBERT GUARINO, M.D., 7620 YORK ROAD TOWSON, MARYLAND 21204</b>  |  |   |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 30 1996</b>  |  |   |  | 32. Registrar's Signature<br>  |  |  |  |  |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a discussion of the experimental design, the data collection procedures, and the statistical analysis techniques.

3. The third part of the report is a discussion of the results of the study. It presents the findings of the research and discusses their implications for the field of study.

4. The fourth part of the report is a conclusion and a list of references. The conclusion summarizes the main findings of the study, and the references list the sources of information used in the research.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25950

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary A. Streeter

2. Date of Death

August 29 1996

3. Time of Death

10:40 PM

4a. Facility Name (If not institution, give street and number)

LIBERTY MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

217-22-6672

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

AUG 30, 1913

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

3321 PRESSTMAN STREET

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8TH

Collage (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DIETARY ASSISTANT

16b. Kind of Business/Industry

SCHOOL SYSTEM

17. Father's Name (First, Middle, Last)

JOHN HALLOWAY

18. Mother's Name (First, Middle, Maiden Surname)

ANNA JANE ENSLEY

19a. Informant's Name/Relationship (Type, Print)

SANFORD STREETER (HUSBAND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3321 PRESSTMAN ST. BALTIMORE, MD. 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

KING MEMORIAL PARK 9/3/96

Date

20c. Location - City or Town, State

RANDALLSTOWN, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

CAPLE FUNERAL SERVICE  
5502 WINNER AVENUE BALTIMORE, MD. 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

Bradycardia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Probable Spinal Cord Injury

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

48 hours

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M.D.

29c. License number

041365

29d. Date signed (Month, Day, Year)

August 29, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George E. Wickes III 2600 Liberty Heights Ave 21215

31. Date filed (Month, Day, Year)

AUG 30 1996

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25951

|   |   |   |  |   |   |  |  |  |   |  |
|---|---|---|--|---|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>BERTHA M. SANDERS</b>                          |   |  |   |   | 2. Date of Death<br>Month <u>August</u> Day <u>26</u> Year <u>1996</u> |  | 3. Time of Death<br><u>3:15 PM</u>   |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Stella Maris Hospice</b> |   |  |   |   | 4b. City, Town, or Location of Death<br><b>Towson</b>                  |  | 4c. County of Death<br><b>Baltimore</b>  |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>212-07-9743</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 6. Date of Birth (Month, Day, Year)<br><b>Sept. 23, 1918</b>                                   |  | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b> |  |
|   | Usual Residence of Decedent   |   |  |   |   |  |  |  |   |  |
| 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Essex</b>   |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |  |
| 10e. Street and Number<br><b>9 Marie Avenue</b>   |   |   |  | 10f. Zip Code<br><b>21221</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>                         |  |  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>   |   |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Michael Kalejta</b>   |   |   |  |   | 16. Mother's Name (First, Middle, Maiden Surname)<br><b>Anne Suchoski</b>   |  |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Richard L. Sanders (HUSBAND)</b>   |   |   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9 Marie Avenue Essex, Md. 21221</b> |  |  |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Meadowridge Mem. Park</b>   |   | Date<br><b>8/30/1996</b>  |  | 20c. Location - City or Town, State<br><b>Howard Co., Md.</b>                                  |  |   |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |   |   |  |   | 22. Name and Address of Facility<br><b>Bruzdzinski Funeral Home P.A.<br/>1407 Old Eastern Avenue Essex, Md. 21221</b>                   |  |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Lung Cancer</u><br>Due to (or as a consequence of):<br><br>b. _____<br>Due to (or as a consequence of):<br><br>c. _____<br>Due to (or as a consequence of):<br><br>d. _____<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |   |   |  |   |   |  |  | Approximate Interval Between Onset and Death<br><u>3 months</u>  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |  |
|   |   |   |  |   |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
|   |   |   |  |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b> |   |   |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   |   | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |  | 28d. Describe how injury occurred                               |  |
|   |   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                   |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner   |   |   | 29b. Signature and title of certifier<br><i>[Signature]</i>  |   |   |  |  |  | 29c. License number<br><b>15504</b>                             |  |
|   |   |   |  |   |   |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>8-29-96</b>           |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DR. EDDIE NAKHUDA 2300 DULANEY VALLEY RD. TOWSON, MD 21204</b>   |   |   |  |   |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 30 1996</b>   |   |   | 32. Registrar's Signature<br><i>[Signature]</i>  |   |   |  |  |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Physician  
/Medical  
Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25952

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

O'DELL N. SMITH

2. Date of Death

AUG. 23, 1996

3. Time of Death

1130 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

3450 WEST CATON AVENUE- IN THE REAR

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

218-94-7331

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

17

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

6/21/79

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

Yes ☒ No ☐

10e. Street and Number

106 N. PAYSON ST

10f. Zip Code

21223

10g. Citizen of What Country?

U.S.A.

11. Marital Status

Never Married ☒ Married ☐  
Widowed ☐ Divorced ☐

12. Was Decedent Ever in U.S.

Armed Forces?  
Yes ☐ No ☒  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)Yes ☐ No ☒ Specify:14. Race - American Indian,  
Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

-0-

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

High School

17. Father's Name (First, Middle, Last)

ROGER SMITH

18. Mother's Name (First, Middle, Maiden Surname)

SHARON SMITH

19a. Informant's Name/Relationship (Type, Print)

CORRINE JACKSON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

112N. CULVER STREET BALTIMORE MD. 21229

20a. Method of Disposition

Burial ☒ Cremation ☐ Removal from State ☐  
Donation ☐ Other (Specify) ☐20b. Place of Disposition (Name of  
cemetery, crematory or other place)

MT. ZION CEM.

Date

8/28/96

20c. Location - City or Town, State

BALTIMORE

21. Signature of Funeral Service Licensee

Dennis J. Chute CFSP#281

22. Name and Address of Facility

E.L. PHILLIPS F.H. P.A.

1721-27 N. MONROE ST. BALTIMORE MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e.

Gunshot Wound of Chest

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

Yes ☐ No ☒ Probably ☐ Unknown ☐24a. Was an autopsy  
performed?Yes ☒ No ☐24b. Were autopsy findings  
available prior to  
completion of cause  
of death?Yes ☒ No ☐25. Was case referred to medical  
examiner?Yes ☒ No ☐

26. Place of Death (Check only one)

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

ALLEY

27. Manner of Death

Natural ☐ Accident ☐ Suicide ☐ Homicide ☒  
Pending investigation ☐ Could not be determined ☐

28a. Date of Injury

(Month, Day, Year)

8/23/96

28b. Time of Injury

11:26 AM

28c. Injury at Work?

Yes ☐ No ☒

28d. Describe how injury occurred

Subject shot

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

street

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)3450 Blk West Caton Ave  
Baltimore, Md29a. Certifier  
(Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dennis J. Chute

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

AUG. 24, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dennis J. Chute

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 30 1996

32. Registrar's Signature

Julia K. Johnson

State  
Registrar

Division of Vital Records, P.O. Box 68760,

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25953

## Certificate of Death

Reg. No.

|   |   |   |   |  |  |   |   |  |
|---|---|---|---|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>FRANK PEARSON SCHAEFER</b>   |   |   |  | 2. Date of Death<br>Month <b>AUGUST</b> Day <b>29</b> Year <b>1996</b>   |   | 3. Time of Death<br><b>5:50 PM</b>                                      |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>HARBOR HOSPITAL CENTER</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |   | 4c. County of Death<br><b>BALTIMORE</b>                                 |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-18-4275</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>May 9, 1925</b>               |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |   |   |  |  |   |   |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |   |   |  |  |   |   |  |
|   | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>  |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|   | 10e. Street and Number<br><b>602 Brian St.</b>  |   |   |  | 10f. Zip Code<br><b>21225</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>  |   | Collega (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Truck Driver</b>   |   | 16b. Kind of Business/Industry<br><b>Trucking Co.</b>                   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Schaefer</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)  |   |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Evelyn McManus</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>602 Brian St. Baltimore, Md. 21225</b>   |   |   |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>  |  | Date<br><b>Aug. 30, 1996</b>   |   | 20c. Location - City or Town, State<br><b>Baltimore, Md.</b>            |  |
|   | 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br><b>Eckhardt Funeral Chapel</b><br><b>11605 Reisterstown Rd. Owings Mills, Md. 21117</b>  |   |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                             |   |   |  |  |   |   |  |
| Physician<br>/Medical<br>Examiner   | Immediate Cause (Final disease or condition resulting in death)<br><b>ACUTE ON CHRONIC RESPIRATORY FAILURE 6 DAYS</b>   |   |   |  |  |   |   |  |
|   | Due to (or as a consequence of):<br><b>END-STAGE OBSTRUCTIVE LUNG DISEASE 20 YEARS</b>  |   |   |  |  |   |   |  |
|   | Due to (or as a consequence of):  |   |   |  |  |   |   |  |
|   | Due to (or as a consequence of):  |   |   |  |  |   |   |  |
|   | Due to (or as a consequence of):  |   |   |  |  |   |   |  |
|   | Due to (or as a consequence of):  |   |   |  |  |   |   |  |
|   | Due to (or as a consequence of):  |   |   |  |  |   |   |  |
|   | Due to (or as a consequence of):  |   |   |  |  |   |   |  |
|   | Due to (or as a consequence of):  |   |   |  |  |   |   |  |
|   | Due to (or as a consequence of):  |   |   |  |  |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |  |  |   |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |   |   |  |  |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
|   |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28d. Describe how injury occurred   |   |  |
|   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><b>HAN WIN TUN, M.D.</b>   |   | 29c. License number<br><b>AS 2441614</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>AUGUST 29 1996</b>                                |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>HAN WIN TUN, M.D. HARBOR HOSPITAL CENTER</b>   |   |   |   |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 30 1996</b>   |   | 32. Registrar's Signature<br>   |   |  |  |   |   |  |

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

10/10/1914

Dear Sir,  
I have the pleasure to acknowledge the receipt of your letter of the 10th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,  
Yours faithfully,  
J. H. [Signature]

Enclosed

For the attention of the [Name] [Address]

Yours faithfully,  
[Signature]

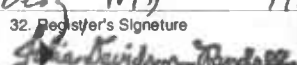
[Address]



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 25954

Reg. No.

|   |  |  |  |   |  |  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|
| <b>Physician<br/>/Medical<br/>Examiner</b>                                  |  | 1. Decedent's Name (First, Middle, Last)<br><p align="center">GRACE ESTELLE SHAFFER</p>  |  |   |  | 2. Date of Death<br>Month Day Year<br>August 24, 1996  |  | 3. Time of Death<br><p align="center">3:00PM</p>  |  |
|   |  | 4e. Facility Name (If not institution, give street and number)<br><p align="center">3017 Third Ave.</p>  |  |   |  | 4b. City, Town, or Location of Death<br><p align="center">Baltimore</p>  |  | 4c. County of Death<br><p align="center">Baltimore</p>  |  |
| <b>Funeral<br/>Director</b>   |  | 5. Social Security Number<br><p align="center">220-54-5533</p>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><p align="center">100 Yrs.</p>   |  | 8. Date of Birth (Month, Day, Year)<br><p align="center">July 23, 1896</p>  |  |
|   |  | 9. Birthplace (State or Foreign Country)<br><p align="center">Maryland</p>   |  | 10a. State<br><p align="center">MD</p>  |  | 10b. County<br><p align="center">Baltimore</p>   |  | 10c. City, Town or Location<br><p align="center">Baltimore</p>  |  |
| <b>To Be Completed by Funeral Director</b>                                  |  | Usual Residence of Decedent  |  |   |  | 10f. Zip Code<br><p align="center">21234</p>   |  | 10g. Citizen of What Country?<br><p align="center">USA</p>  |  |
|   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <p align="center">7</p> College (1-4or 5+) <p align="center">College</p>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><p align="center">Homemaker</p>   |  | 16b. Kind of Business/Industry<br><p align="center">Own Home</p>  |  |
| <b>Physician<br/>/Medical<br/>Examiner</b>                                  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <p align="center">White</p>  |  |
|   |  | 17. Father's Name (First, Middle, Last)<br><p align="center">Charles Wesley Shaeffer</p>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><p align="center">Emma Jane Henry</p>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><p align="center">Gloria Marken</p>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><p align="center">3017 Third Ave., Baltimore, MD 21234</p>   |  |
| <b>Physician<br/>/Medical<br/>Examiner</b>                                  |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><p align="center">Greenmount Cemetery</p>                                   |  | Date<br><p align="center">8/29/96</p>  |  | 20c. Location - City or Town, State<br><p align="center">Hampstead, MD</p>  |  |
|   |  | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><p align="center">ALTENBURG FUNERAL HOME, P.A.<br/>6009 Harford Rd., Baltimore, MD 21214</p>                      |  | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><p align="center">a. <i>Cerebral aneurysm of Basal ganglia, right</i><br/>Due to (or as a consequence of):<br/>b. <i>Arteriosclerotic Heart Disease</i><br/>Due to (or as a consequence of):<br/>c. <i>Cardiac Failure</i><br/>Due to (or as a consequence of):<br/>d. _____</p> |  | Approximate interval between Onset and Death  |  |
| <b>Medical Certification: To Be Completed by Physician/Medical Examiner</b> |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |
|   |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |
| <b>State<br/>Registrar</b>  |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><p align="center">M</p>   |  | 28c. Injury et Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
|   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how injury occurred   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| <b>State<br/>Registrar</b>  |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  | 29b. Signature and title of certifier<br><p align="center">Sylvan D Goldberg, MD</p>  |  |
|   |  | 29c. License number<br><p align="center">DO 1433</p>   |  | 29d. Date signed (Month, Day, Year)<br><p align="center">August 26, 1996</p>  |  |  |  |   |  |
| <b>State<br/>Registrar</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><p align="center">Sylvan D Goldberg MD 7121 Park Heights Ave</p>   |  |   |  |  |  | 31. Date filed (Month, Day, Year)<br><p align="center">AUG 30 1996</p>  |  |
|   |  | 32. Registrar's Signature<br>   |  |   |  |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

1. The first part of the document is a list of names and addresses.

2. The second part of the document is a list of names and addresses.

3. The third part of the document is a list of names and addresses.

4. The fourth part of the document is a list of names and addresses.

5. The fifth part of the document is a list of names and addresses.

6. The sixth part of the document is a list of names and addresses.

7. The seventh part of the document is a list of names and addresses.

8. The eighth part of the document is a list of names and addresses.

9. The ninth part of the document is a list of names and addresses.

10. The tenth part of the document is a list of names and addresses.

11. The eleventh part of the document is a list of names and addresses.

12. The twelfth part of the document is a list of names and addresses.

13. The thirteenth part of the document is a list of names and addresses.

14. The fourteenth part of the document is a list of names and addresses.

15. The fifteenth part of the document is a list of names and addresses.

16. The sixteenth part of the document is a list of names and addresses.

17. The seventeenth part of the document is a list of names and addresses.

18. The eighteenth part of the document is a list of names and addresses.

ITEM: 1. PER DR. FILM G-739  
9/5/96 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25955

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

~~Mary Ethel Savage~~

ETHEL MARY SAVAGE

2. Date of Death

Month  
Aug

Day  
19

Year  
1996

3. Time of Death

5:25 a.m.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Pickersgill, Inc.

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

217-26-6723

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

97

8. Date of Birth

Month Day Year

9. Birthplace (State or Foreign Country)

Oct. 27, 1898

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Eudowood

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

615 Chestnut Avenue

10f. Zip Code

21204

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

unknown

College (1-4 or 5+)

unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Salesperson

16b. Kind of Business/Industry

unknown

17. Father's Name (First, Middle, Last)

Charles Wesley Pardoe

18. Mother's Name (First, Middle, Maiden Surname)

Saphire Elizabeth Wilson

19a. Informant's Name/Relationship (Type, Print)

Virginia Kirk/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

711 Maiden Choice Lane-Catonsville, Maryland 21228

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Dir.

22. Name and Address of Facility

State Anatomy Board-655 W. Baltimore, Street  
Baltimore, Maryland 21201-1559

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. dementia

2 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

NA

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

W. A. Riley M.D.

29c. License number

025205

29d. Date signed (Month, Day, Year)

August 19, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. A. Riley G.B.M.C. 6701 N. Charles Street, Balt. Md.

31. Date filed (Month, Day, Year)

AUG 23 1996

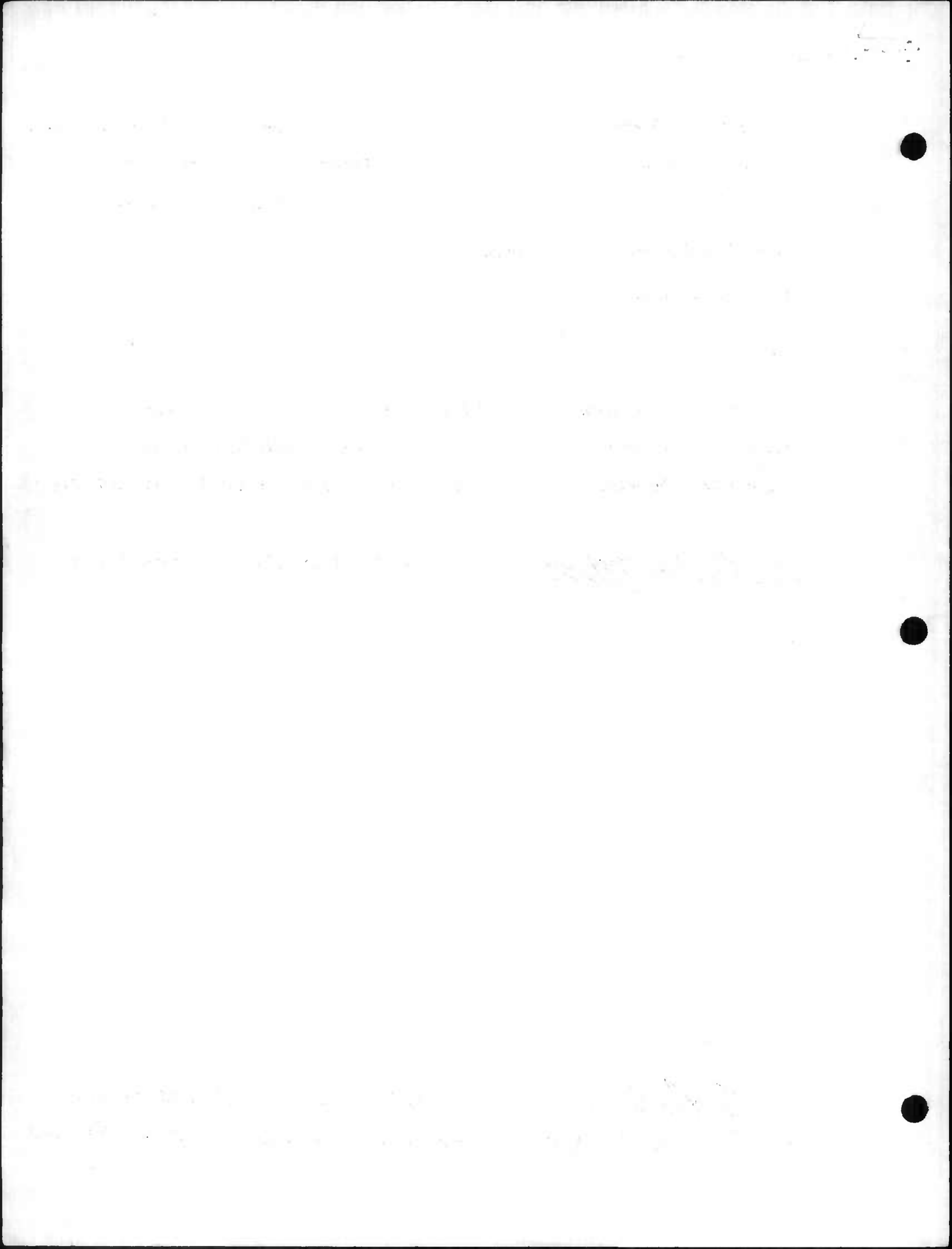
32. Registrar's Signature

Julia Davidson-Randall

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25956

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Emma M. Schneider

2. Date of Death

August 27, 1996

3. Time of Death

1:00 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

3838 Roland Avenue Apt. 1306

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

5. Social Security Number

215-28-4964

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 28, 1931

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore City

10c. City, Town or Location

Baltimore

10d. Inside City Limits

XX Yes 2 ☐ No

10e. Street and Number

3838 Roland Avenue Apt. 1306

10f. Zip Code

21211

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Johns Hopkins Hospital

17. Father's Name (First, Middle, Last)

Walter Standiford

18. Mother's Name (First, Middle, Maiden Surname)

Emma M. Hare

19a. Informant's Name/Relationship (Type, Print)

John Morgan

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

313 South Newkirk Street Baltimore, MD 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sater's Cemetery

Date

8/30/96

20c. Location - City or Town, State

Brooklandville, MD

21. Signature of Funeral Service Licensee

Lucy Henss Carpenter

22. Name and Address of Facility

Burgee-Henss Funeral Home  
3631 Falls Road Baltimore, Maryland 21211

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Gregory J. Stelkum

29c. License number

D25612

29d. Date signed (Month, Day, Year)

8/28/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

GREGORY WALKER, MD UNION MEMORIAL HOSPITAL BALTIMORE, MD.

State  
Registrar

31. Date filed (Month, Day, Year)

AUG 30 1996

32. Registrar's Signature

Vicki R. Riddle

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25957

## Certificate of Death

Reg. No.

|   |   |  |   |   |  |  |  |   |  |  |   |
|---|---|--|---|---|--|--|--|---|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Evelyn M. Steffey   |  |   |   | 2. Date of Death<br>Month Day Year<br>8 27 96        |  |  |   | 3. Time of Death<br>5:00 PM                                      |  |   |
|   | 4a. Facility Name (If not institution, give street and number)<br>Cherrywood Manor Extended Care Center |  |   |   | 4b. City, Town, or Location of Death<br>Reisterstown |  |  |   | 4c. County of Death<br>Baltimore County                          |  |   |
| Funeral<br>Director   | 5. Social Security Number<br>214-01-3373  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>86 Yrs.            |  | 8. Date of Birth (Month, Day, Year)<br>9/23/1909 |   | 9. Birthplace (State or Foreign Country)<br>Maryland             |  |   |
|   | Usual Residence of Decedent   |  |   |   | 10a. State<br>Maryland                               |  |  |   | 10b. County<br>Baltimore County                                  |  | 10c. City, Town or Location<br>Reisterstown |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |   | 10e. Street and Number<br>12020 Reisterstown Road   |  |  |  | 10f. Zip Code<br>21136  |  | 10g. Citizen of What Country?<br>U.S.A.  |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 6 College (1-4 or 5+)  |   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Home Maker   |  |  |  | 16b. Kind of Business/Industry<br>Own Home  |  |  |   |
| 17. Father's Name (First, Middle, Last)<br>Ulysses Taylor   |   |  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Effie Buchman   |  |   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>Brenda Mathias (Daughter)   |   |  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4004 Rouen Road, Randallstown, MD 21133   |  |   |  |  |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Moreland Memorial Park  |  |  |  | 20c. Location - City or Town, State<br>8/30/96 Parkville, Maryland                              |  |  |   |
| 21. Signature of Funeral Service Licensee<br>A. Alan Seitz, Jr.   |   |  |   |   |  | 22. Name and Address of Facility<br>A. Alan Seitz, Jr. Funeral Home, Balto., MD 21211  |  |   |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Multifactorial Dementia<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |  |   |   |  |  |  |   |  | Approximate Interval Between Onset and Death<br>2 years  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |   |   |  |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |
|   |   |  |   |   |  |  |  |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |
|   |   |  |   |   |  |  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   |  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 28d. Describe how Injury occurred  |   |
|   |   |  |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                    |  |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |  |   |   |  |  |  |   |  |  |   |
| 29b. Signature and title of certifier<br>Irving Hunter Copeland MD  |   |  |   |   |  | 29c. License number<br>D27034  |  |   | 29d. Date signed (Month, Day, Year)<br>August 29 1996            |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Irving Hunter Copeland MD 5310 Old Court Road Suite 201 Randallstown MD 21133   |   |  |   |   |  |  |  |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br>AUG 30 1996  |   |  |   | 32. Registrar's Signature<br>Julia Wilson-Randall   |  |  |  |   |  |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

5

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25958

## Certificate of Death

Reg. No.

|   |  |                           |   |  |   |  |   |  |  |  |
|---|--|---------------------------|---|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last) <u>Lillian Josephine Stackowski</u><br><u>AKA-Lillian Stack</u> |                           |   |  |   |  | 2. Date of Death<br>Month <u>August</u> Day <u>28</u> Year <u>1996</u>                      |  | 3. Time of Death<br><u>11:07 AM</u>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><u>Mercy Medical Center</u>            |                           |   |  |   |  | 4b. City, Town, or Location of Death<br><u>Baltimore City</u>                               |  | 4c. County of Death<br><u>N/A</u>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><u>213-05-4574</u>  |                           | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><u>82</u> Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><u>Feb. 13, 1914</u>                                 |  | 9. Birthplace (State or Foreign Country)<br><u>Maryland</u>                  |  |
|   | Usual Residence of Decedent  |                           |   |  |   |  |   |  |  |  |
| 10a. State<br><u>Maryland</u>   |  | 10b. County<br><u>N/A</u> |   | 10c. City, Town or Location<br><u>Baltimore City</u>   |   |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |
| 10e. Street and Number<br><u>6919 Gough Street</u>  |  |                           |   | 10f. Zip Code<br><u>21224</u>  |   | 10g. Citizen of What Country?<br><u>U.S.A.</u>   |   |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u>  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>9th Grade</u>   |  |                           |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Factory Worker</u> |   |  | 16b. Kind of Business/Industry<br><u>Clothing</u>   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><u>William Henry York</u>  |  |                           |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Anna Unknown Ahrens</u>  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>Vivian Pondo - Niece</u>   |  |                           |   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>1714 Beachwood Avenue, Baltimore, Maryland 21221</u> |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Ebenezer Cemetery</u>  |  | Data<br><u>8/31/96</u>  |  | 20c. Location - City or Town, State<br><u>Baltimore, Maryland</u>                           |  |  |  |
| 21. Signature of Funeral Service Licensee<br><u>Kathleen M. Murphy</u>  |  |                           |   |  |   | 22. Name and Address of Facility<br><u>John C. Miller, Inc.</u><br><u>6415 Belair Road, Baltimore, Maryland 21206</u>                                    |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><u>Sepsis</u><br>Due to (or as a consequence of):<br><u>Renal Failure</u><br>Due to (or as a consequence of):<br><u>Pleural Effusion</u><br>Due to (or as a consequence of):<br><br>Sequitentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>Approximate Interval Between Onset and Death<br><u>2 days</u><br><u>2 days</u><br><u>3 days</u> |  |                           |   |  |   |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |                           |   |  |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
|   |  |                           |   |  |   |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
|   |  |                           |   |  |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                           | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  |                           | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how Injury occurred  |  |
|   |  |                           | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |                           |   |  |   |  |   |  |  |  |
| 29b. Signature and title of certifier<br><u>Vijay Pethkar MD</u>  |  |                           |   | 29c. License number<br><u>050853</u>   |   |  | 29d. Date signed (Month, Day, Year)<br><u>8/28/96</u>                                       |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>Vijay Pethkar 301 St. Paul Place, Baltimore MD 21208</u>   |  |                           |   |  |   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><u>AUG 30 1996</u>   |  |                           | 32. Registrar's Signature<br><u>J. A. Wilson-Randall</u>  |  |   |  |   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25959

Certificate of Death

Reg. No.

|   |  |  |  |  |  |  |  |   |
|---|--|--|--|--|--|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>GEORGE TURNER</b>                                     |  |  |  | 2. Date of Death<br>Month <b>August</b> Day <b>28</b> Year <b>1996</b> |  | 3. Time of Death<br><b>5:00 AM</b>   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>STELLA MARIS NURSING CENTER</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>               |  | 4c. County of Death<br><b>BALTIMORE</b>  |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>218-84-7218</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>34</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>5-12-62</b>  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |
|   | Usual Residence of Decedent  |  |  |  |  |  |  |   |
| 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>N/A</b>  |  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
| 10e. Street and Number<br><b>3315 WOODLAND AVENUE</b>   |  |  |  | 10f. Zip Code<br><b>21215</b>  |  | 10g. Citizen of What Country?<br><b>US</b>   |  |   |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>  |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>-0-</b>  |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SALEMAN</b>  |  | 16b. Kind of Business/Industry<br><b>SALES</b>   |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>JOSEPH TURNER</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ADELLE CHAMBERS</b>  |  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>LEONARD PATTERSON (GOD FATHER)</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4110 KATHLAND AVE. BALIO., MD. 21215</b>   |  |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>KING MEM. PK.</b>   |  | Date<br><b>8/31/96</b>   |  | 20c. Location - City or Town, State<br><b>BALTIO., MD.</b>   |  |   |
| 21. Signature of Funeral Service Licensee<br><i>Shannon Stokes</i>  |  |  |  | 22. Name and Address of Facility<br><b>BAILEY FUNERAL SERVICE<br/>3612 RIDGEWOOD AVE. BALTO., MD. 21215</b>  |  |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. ACQUIRED IMMUNE DEFICIENCY SYNDROME</b><br>Due to (or as a consequence of):<br><b>b. HIV INFECTION</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>UNKNOWN</b><br><br><b>~ 5 years</b>  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |
|   |  |  |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b> |  |  |  |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |  |  |  |  |  |   |
| 29b. Signature and title of certifier<br><i>Dr. Fernando J. Ferrero</i>   |  |  |  | 29c. License number<br><b>D40480</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>Aug. 28, 1996</b>  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>FERNANDO J. FERRERO, MD<br/>BALTO., MD 21206</b>   |  |  |  |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>AUG 30 1996</b>   |  |  |  | 32. Registrar's Signature<br><i>Julia Carter</i>   |  |  |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Film G741 item 14 per FH 11-27-96 rja

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 25960

Reg. No.

|   |   |  |  |  |  |  |   |  |
|---|---|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Elvira Thompson</b>  |  |  |  | 2. Date of Death<br>Month <b>August</b> Day <b>19</b> Year <b>1996</b>   |  | 3. Time of Death<br><b>2:30 p.m.</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>JOHNS HOPKINS - Bayview Medical Center</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>N/A</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>448-84-2701</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>July 15, 1923</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>PANAMA</b>   |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>N/A</b>  |  | 10c. City, Town or Location<br><b>BALTIMORE</b>   |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>3127 Wallick Drive #D</b>   |  | 10f. Zip Code<br><b>21222</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: <b>PANAMANIAN</b> |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Panamanian</b>  |  |
| To Be Completed by Physician/Medical Examiner   | 15. Decedent's Education (Specify only highest grade completed)<br><b>5th grade</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use rating)<br><b>Housewife</b>   |  | 16b. Kind of Business/Industry<br><b>San Home</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>GEORGE RIVIERE</b>  |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Wilhelmina Hector</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>BARBARA Hughes</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3127 Wallick Drive #D BALTIMORE, MD 21222</b>  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |
| Physician<br>/Medical<br>Examiner   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Western Star Cemetery</b>  |  | 20c. Date<br><b>8-24-96</b>  |  | 20d. Location - City or Town, State<br><b>Cotonsville, Md</b>  |  | 21. Signature of Funeral Service Licensee<br><b>Gray Harris</b>   |  |
|   | 22. Name and Address of Facility<br><b>CHAIRMAN - HARRIS F.H. 5245 REISTERSTOWN ROAD BALTIMORE, MD 21215</b>  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Arrhythmia</b><br>Due to (or as a consequence of):<br><b>b. Renal failure</b><br>Due to (or as a consequence of):<br><b>c. Coronary artery disease</b><br>Due to (or as a consequence of):<br><b>d. Peripheral vascular disease</b> |  | Approximate Interval Between Onset and Death<br><b>days</b><br><b>years</b><br><b>years</b><br><b>years</b>  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                      |  |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020   | 23c. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 23d. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b><br><b>Prior cerebrovascular accidents</b>                             |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>   |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>Kevin J. Shannon MD Resident</b>   |  | 29c. License number<br><b>96023</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>August 20, 1996</b>   |  |
| State Registrar   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>KEVIN J. SHANNON MD 4940 Eastern Avenue, Baltimore, MD 21224</b>   |  | 31. Date filed (Month, Day, Year)<br><b>AUG 30 1996</b>  |  | 32. Registrar's Signature<br><b>Don Randall</b>  |  |   |  |



## Certificate of Death

Reg. No.

|   |  |  |   |   |  |  |  |
|---|--|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>CARL F VENZKE 3rd.</b>  |  |   | 2. Date of Death<br>Month <b>AUGUST</b> Day <b>27</b> , Year <b>1996</b>  |  | 3. Time of Death<br><b>13:35 P</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>20 MILDEN CT.</b>   |  |   | 4b. City, Town, or Location of Death<br><b>Middle River</b>   |  | 4c. County of Death<br><b>BALTIMORE</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>213-86-6480</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>33</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>April 14, 1963</b>                                   |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |   |   |  |  |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent  |  |   |   |  |  |  |
|   | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Baltimore</b>   |   | 10c. City, Town or Location<br><b>Middle River</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|   | 10e. Street and Number<br><b>20 Milden Court</b>   |  |   | 10f. Zip Code<br><b>21220</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                   |  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Chef</b>                          |   | 16b. Kind of Business/Industry<br><b>Catering Food</b>   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Carl F. Venzke Jr.</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Leona Kelly</b>   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Carl F. Venzke Jr. (Father)</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>21 Milden Court Middle River, Md. 21220</b> |  |  |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Greenmount Crematory</b>   |   | 20c. Location - City or Town, State<br><b>8/30/1996 Baltimore City</b>   |  |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>BRUDZINSKI Funeral Home P.A.<br/>1407 Old Eastern Avenue Essex, Md. 21221</b>                              |   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>CONGENITAL AORTIC STENOSIS WITH SECONDARY LEFT VENTRICULAR HYPERTROPHY</b> |  |   |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |  |   |   |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |   |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |   |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |   |   |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |   |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred  |   |   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |   |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |   |  |  |  |
| 29b. Signature and title of certifier<br>  |  |  | 29c. License number<br><b>OCME</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>AUGUST 28, 1996</b>  |  |  |
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print)<br><b>Theodor M. Kujawa 111 Penn Street, Baltimore, Maryland 21201</b>   |  |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 30 1996</b>   |  | 32. Registrar's Signature<br> |   |   |  |  |  |

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

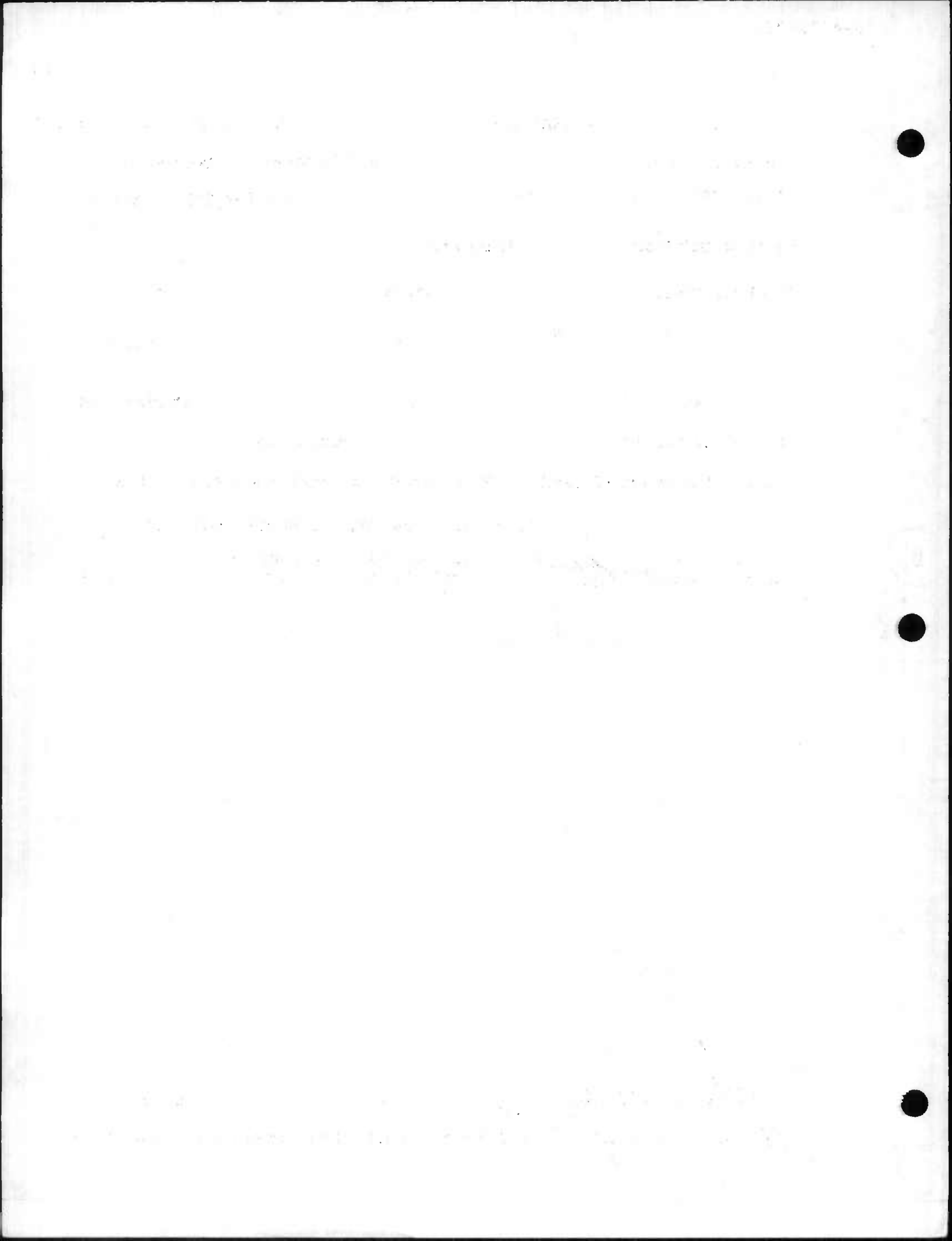
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner






Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene


96 25962

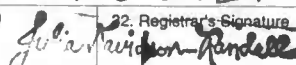
## Certificate of Death

Reg. No.

|  |   |  |   |                           |   |  |  |  |  |    |                                 |                |    |  |                |    |  |  |    |  |
|--|---|--|---|---------------------------|---|--|--|--|--|----|---------------------------------|----------------|----|--|----------------|----|--|--|----|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Louis Bitzel Williar</b>   |  |   |                           | 2. Date of Death<br>Month <b>August</b> Day <b>27</b> Year <b>1996</b>  |  | 3. Time of Death<br><b>8:35 am</b>   |  |  |    |                                 |                |    |  |                |    |  |  |    |  |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>Meridian Nursing Center- Loch Raven</b>  |  |   |                           | 4b. City, Town, or Location of Death<br><b>Towson</b>   |  | 4c. County of Death<br><b>Baltimore</b>  |  |  |    |                                 |                |    |  |                |    |  |  |    |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>213-01-7945</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.  | If Under 1 Year<br>Months | If Under 24 Hrs.<br>Hours   | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 1, 1909</b> | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                    |  |  |    |                                 |                |    |  |                |    |  |  |    |  |
|  | Usual Residence of Decedent   |  |   |                           |   |  |  |  |  |    |                                 |                |    |  |                |    |  |  |    |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>   |                           | 10c. City, Town or Location<br><b>Essex</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |    |                                 |                |    |  |                |    |  |  |    |  |
|  | 10e. Street and Number<br><b>111 Judywood Lane</b>  |  |   |                           | 10f. Zip Code<br><b>21221</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |    |                                 |                |    |  |                |    |  |  |    |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                           | 13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |  |    |                                 |                |    |  |                |    |  |  |    |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) unknown</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Delivery Driver</b>               |                           | 16b. Kind of Business/Industry<br><b>Dairy</b>  |  |  |  |  |    |                                 |                |    |  |                |    |  |  |    |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>unknown</b>   |  |   |                           | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>unknown</b>   |  |  |  |  |    |                                 |                |    |  |                |    |  |  |    |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Eugene Bengles</b>   |  |   |                           | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>948 Kinwat Ave. Baltimore, Maryland 21221</b>   |  |  |  |  |    |                                 |                |    |  |                |    |  |  |    |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Oak Lawn Cemetery</b>  |                           | Date<br><b>8/29/96</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore County, Md.</b>                            |  |  |    |                                 |                |    |  |                |    |  |  |    |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  |   |                           | 22. Name and Address of Facility<br><b>Bruzdzinski Funeral Home P.A.<br/>1407 Old Eastern Ave. Essex, Md. 21221</b>   |  |  |  |  |    |                                 |                |    |  |                |    |  |  |    |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |                           |   |  |  |  |  |    |                                 |                |    |  |                |    |  |  |    |  |
|  | <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           {<br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>Congestive Heart Failure</b></td> <td><b>4 years</b></td> </tr> <tr> <td>b.</td> <td><b>Chronic Urinary Tract Infection</b></td> <td><b>4 years</b></td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> |  |   |                           |   |  |  |  | Immediate Cause (Final disease or condition resulting in death)<br><br>{<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | <b>Congestive Heart Failure</b> | <b>4 years</b> | b. | <b>Chronic Urinary Tract Infection</b> | <b>4 years</b> | c. |  |  | d. |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>{<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a.  | <b>Congestive Heart Failure</b>  | <b>4 years</b>  |                           |   |  |  |  |  |    |                                 |                |    |  |                |    |  |  |    |  |
|  | b.  | <b>Chronic Urinary Tract Infection</b>                                     | <b>4 years</b>  |                           |   |  |  |  |  |    |                                 |                |    |  |                |    |  |  |    |  |
|  | c.  |  |   |                           |   |  |  |  |  |    |                                 |                |    |  |                |    |  |  |    |  |
|  | d.  |  |   |                           |   |  |  |  |  |    |                                 |                |    |  |                |    |  |  |    |  |

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |  |
|  |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |

|  |  |   |  |                                       |  |  |  |
|--|--|---|--|---------------------------------------|--|--|--|
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                       |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28e. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>       |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
|  |  | 28d. Describe how injury occurred   |  |                                       |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)     |  |
| 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |                                       |  |  |  |
| 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br><b>D 15414</b> |  | 29d. Date signed (Month, Day, Year)<br><b>8/27/96</b>                            |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Vuong Vu NGUYEN 6 Linlow Ct Towson MD 21286</b>   |  |   |  |                                       |  |  |  |

|                 |   |  |
|-----------------|---|--|
| State Registrar | 31. Date filed (Month, Day, Year)<br><b>AUG 30 1996</b> | 32. Registrar's Signature<br> |
|-----------------|---|--|

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25963

## Certificate of Death

Reg. No.

|  |  |  |   |  |  |  |  |  |
|--|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Virly P. Wood  |  |   |  | 2. Date of Death<br>Month Day Year<br>Aug 27, 1996   |  | 3. Time of Death<br>8:55 AM  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>5217 Wilton Heights  |  |   |  | 4b. City, Town, or Location of Death<br>Baltimore  |  | 4c. County of Death<br>NA  |  |
| Funeral<br>Director  | 5. Social Security Number<br>212-26-9422   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>67 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Feb 27, 1929  |  |
|  | 9. Birthplace (State or Foreign Country)<br>Md   |  | 10a. State<br>Md  |  | 10b. County<br>NA  |  | 10c. City, Town or Location<br>Baltimore   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 10e. Street and Number<br>5217 Wilton Heights   |  | 10f. Zip Code<br>21215   |  | 10g. Citizen of What Country?<br>U. S. A   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever In U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black   |  |
| To Be Completed by Physician/Medical Examiner                                | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>10th grade   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Domestic Worker  |  | 16b. Kind of Business/Industry<br>Private Home   |  | 17. Father's Name (First, Middle, Last)<br>Richard Thomas  |  |
|  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mable Texar   |  | 19a. Informant's Name/Relationship (Type, Print)<br>Charles Wood - Husband  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5217 Wilton Heights Baltimore Md 21215  |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |
| Physician<br>/Medical<br>Examiner  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>King Memorial Park   |  | 20c. Date<br>8/31/96  |  | 20d. Location - City or Town, State<br>Randallstown, Md  |  | 21. Signature of Funeral Service Licensee<br>Shannon Stiles  |  |
|  | 22. Name and Address of Facility<br>March F.H. West<br>4300 Wabash Avenue Baltimore, Md 21215  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. liver carcinoma - primary uncertain<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  | Approximate Interval Between Onset and Death<br>1 1/2 mos.   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |
| Division of Vital Records, P.O. Box 68760,<br>Baltimore, Maryland 21215-0020 | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| State<br>Registrar   | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |
|  | 29b. Signature and title of certifier<br>Yvonne Ottaviano MD   |  | 29c. License number<br>D40850   |  | 29d. Date signed (Month, Day, Year)<br>August 27, 1996   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>YVONNE OTTAVIANO MD - 900 CATON AVE BALTIMORE MD 21229   |  |
| 31. Date filed (Month, Day, Year)<br>AUG 30 1996                             |  | 32. Registrar's Signature<br>John Davidson-Randall |   |  |  |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25964

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Howard Wilson

2. Date of Death

Month Day Year  
August 26 1996

3. Time of Death

5:25 A.M.

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

216-01-7592

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 12, 1910

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2415 Kentucky Avenue

10f. Zip Code

21213

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: WW II13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12 years

College (1-4or 5+)

16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Brick Layer

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

John Wilson

18. Mother's Name (First, Middle, Maiden Surname)

Leanna Pyrtle

19a. Informant's Name/Relationship (Type, Print)

Anne Wilson (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2415 Kentucky Avenue, Baltimore, Maryland 21213

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify) Intombment20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Lorraine Park Mausoleum

Date

8-28

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Home

3331 Brehms Lane, Baltimore, Maryland 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Thoracic Aortic Aneurysm dissection  
Due to (or as a consequence of):

8 hr

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Atherosclerotic Vascular disease  
Due to (or as a consequence of):

20 years

c. hypertension  
Due to (or as a consequence of):

40 years

d.

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive lung disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Wael Samara, M.D.

29c. License number

AT 2438946

29d. Date signed (Month, Day, Year)

8/26/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Wael Samara, Union Memorial Hospital

31. Date filed (Month, Day, Year)

AUG 30 1996

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director




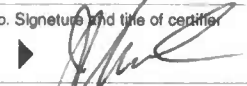
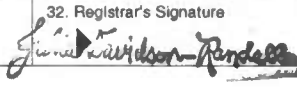
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25965

## Certificate of Death

Reg. No.

|   |  |  |   |  |   |  |  |  |
|---|--|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Ruth Francis Walkling</b>   |  |   |  | 2. Date of Death<br>Month <b>August</b> Day <b>23</b> , Year <b>1996</b>  |  | 3. Time of Death<br><b>2:10 P.M.</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Genesis Eldercare Center</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Parkville</b>  |  | 4c. County of Death<br><b>Baltimore</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>216-14-0888</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 6, 1917</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Connecticut</b>   |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Parkville</b>  |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>1801 Wentworth Road</b>  |  | 10f. Zip Code<br><b>21234</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>11</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Self-Employed</b>   |  | 16b. Kind of Business/Industry<br><b>Farmer - Housewife</b>   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Howard J. Pearsall</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Maude Hinton</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. Ralph A. Walkling /Son</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2357 McCauley Court Columbus, OH 43220</b> |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                      |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Druid Ridge Cemetery</b>   |  | 20c. Date<br><b>8/26</b>  |  | 20d. Location - City or Town, State<br><b>Pikesville, Maryland</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Loring Byers Funeral Directors, Inc.</b><br><b>8728 Liberty Road Randallstown, MD 21133</b>  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>Immediate Cause (Final disease or condition resulting in death)</b><br>a. <b>Cerebrovascular Accident</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br><b>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</b> |  | Approximate Interval Between Onset and Death<br><b>1 Day</b>   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |  |  |
|   |  |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No        |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
|   |  | 28d. Describe how injury occurred  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br> |   | 29c. License number<br><b>D43420</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>8/26/96</b>                        |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Joseph Sniadach DO 7600 Oster Dr. Suite 315 Towson MD 21204</b>  |  |  |   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 30 1996</b>   |  | 32. Registrar's Signature<br>             |   |  |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

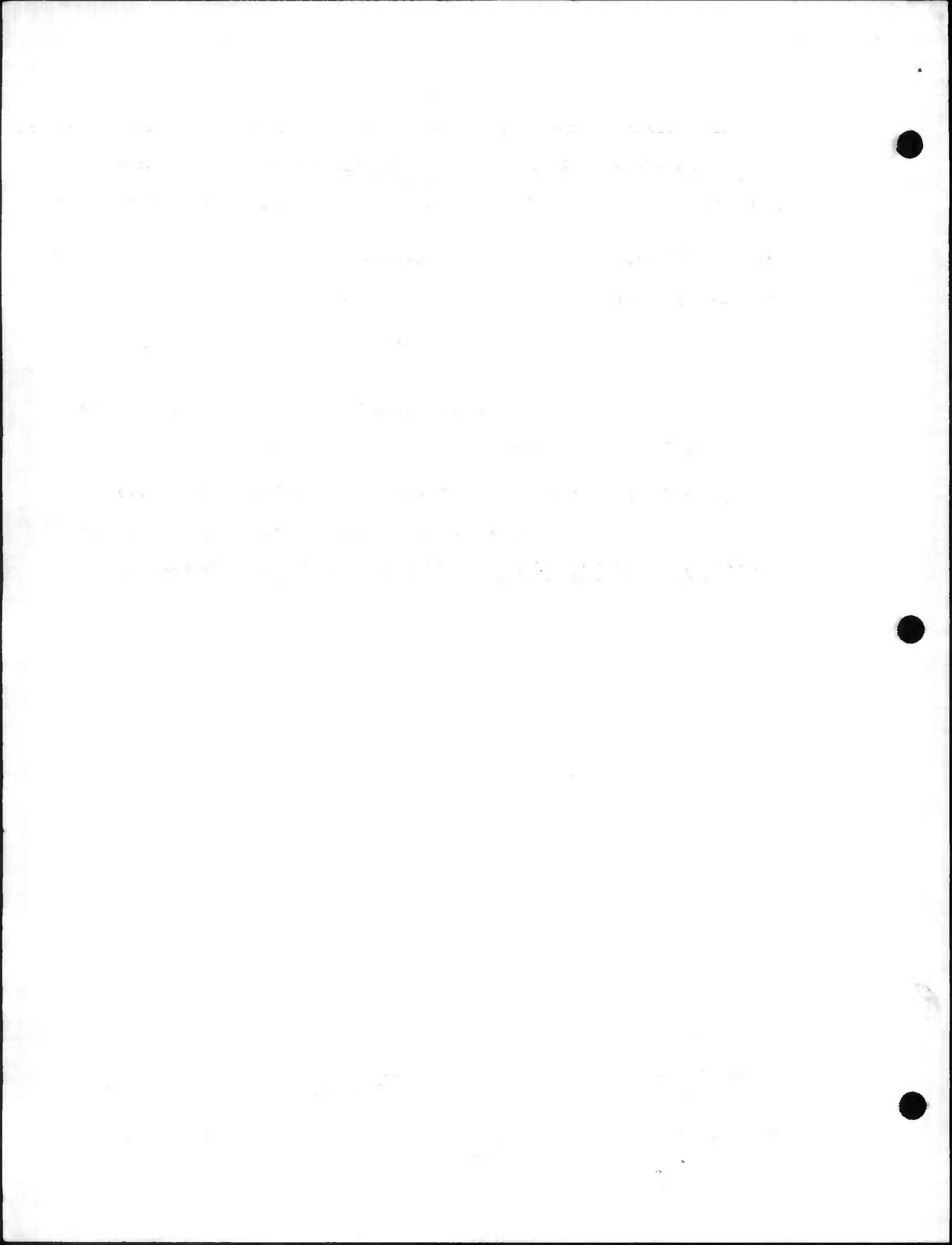
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25966

## Certificate of Death

Reg. No.

|   |   |  |   |                               |  |  |   |  |  |  |  |  |                                   |  |
|---|---|--|---|-------------------------------|--|--|---|--|--|--|--|--|-----------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Janet Geraldine Adams   |  |   |                               | 2. Date of Death<br>Month Day Year<br>August 12, 1996  |  |   |  | 3. Time of Death<br>11:29 AM   |  |  |  |                                   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>907 Shelby Drive  |  |   |                               | 4b. City, Town, or Location of Death<br>Oxon Hill  |  |   |  | 4c. County of Death<br>Prince George's   |  |  |  |                                   |  |
| Funeral<br>Director   | 5. Social Security Number<br>218-34-7479  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |                               | 7. Age (In yrs. last birthday)<br>58 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>6-6-38 |  | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |  |  |                                   |  |
|   | Usual Residence of Decedent   |  |   |                               |  |  |   |  |  |  |  |  |                                   |  |
| To Be Completed by<br>Funeral Director  | 10a. State<br>Maryland  |  | 10b. County<br>Prince George's  |                               | 10c. City, Town or Location<br>Oxon Hill   |  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |  |                                   |  |
|   | 10e. Street and Number<br>907 Shelby Drive  |  |   |                               | 10f. Zip Code<br>20745   |  |   |  | 10g. Citizen of What Country?<br>USA   |  |  |  |                                   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                               | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                               |  |  |  |                                   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11th College (1-4or 5+)  |  |   |                               | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Meat Wrapper  |  |   |  | 16b. Kind of Business/Industry<br>Grocery Store  |  |  |  |                                   |  |
|   | 17. Father's Name (First, Middle, Last)<br>Leo William Rison  |  |   |                               | 18. Mother's Name (First, Middle, Maiden Surname)<br>Virginia Louise Patrone   |  |   |  |  |  |  |  |                                   |  |
| To Be Completed by<br>Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br>Joseph R. Adams/ Husband  |  |   |                               | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>907 Shelby Drive Oxon Hill, Maryland 20745  |  |   |  |  |  |  |  |                                   |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |                               | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metropolitan Crematory 8-13-96   |  |   |  | 20c. Location - City or Town, State<br>Alexandria, Virginia                                    |  |  |  |                                   |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  |   |                               | 22. Name and Address of Facility<br>George P. Kalas Funeral Home<br>6160 Oxon Hill Rd. Oxon Hill, Md. 20745  |  |   |  |  |  |  |  |                                   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Squamous cell lung cancer, stage II</i><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |                               |  |  |   |  |  |  |  |  |                                   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown<br><br>24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br><br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |                               |  |  |   |  |  |  |  |  |                                   |  |
| State<br>Registrar  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |                               |  |  |   |  |  |  |  |  |                                   |  |
|   | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |                               |  |  |   |  |  |  |  |  |                                   |  |
|   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |                               |  |  |   |  |  |  |  |  |                                   |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |   |                               | 28a. Date of Injury (Month, Day Year)  |  |   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred |  |
|   |   |  |   |                               | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                   |  |  |  |                                   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |                               |  |  |   |  |  |  |  |  |                                   |  |
| 29b. Signature and title of certifier<br>   |   |  |   | 29c. License number<br>D14730 |  |  |   | 29d. Date signed (Month, Day, Year)<br>8/12/1996 |  |  |  |  |                                   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>8926 Woodyard Rd Suite 201 Clinton, MD 20735 Dr. Kai-Yin Yeung  |   |  |   |                               |  |  |   |  |  |  |  |  |                                   |  |
| 31. Date filed (Month, Day, Year)<br>AUG 13 1996  |   |  |   | 32. Registrar's Signature<br> |  |  |   |  |  |  |  |  |                                   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25967

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

PATRICIA A. AUSTELL

2. Date of Death

August 7 1996

3. Time of Death

7:25AM

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

262 66 1198

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

55 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

June 25, 1941

9. Birthplace (State or Foreign Country)

Florida

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

12304 Manship Lane

10f. Zip Code

20715

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Lucius Tuttle

18. Mother's Name (First, Middle, Maiden Surname)

Maroy Fountain

19a. Informant's Name/Relationship (Type, Print)

Claude L. Austell Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12304 Manship Lane Bowie Maryland 20715

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

8/11/96

20c. Location - City or Town, State

Alexandria Virginia

21. Signature of Funeral Service Licensee

Robert E. Evans, Pres

22. Name and Address of Facility

Robert E. Evans Funeral Home, P.A.

16000 Annapolis Rd. Bowie Md. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MASSIVE GASTRIC BLEED

Due to (or as a consequence of):

b. ESOPHAGEAL VARICES

Due to (or as a consequence of):

c. CIRRHOSIS OF LIVER

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RECENT MYOCARDIAL INFARCTION

RECENT ANEURYSMECTOMY OF HEART

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

Sudhakar Punga

29c. License number

D20072

29d. Date signed (Month, Day, Year)

8/8/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sudhakar Punga M.D. 7219 Hanover Parkway Greenbelt Maryland 20770

31. Date filed (Month, Day, Year)

AUG 14 1996

32. Registrar's Signature

John D. Anderson

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

10

[illegible]

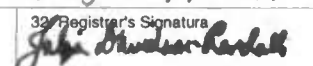
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25968

## Certificate of Death

Reg. No.

|   |  |  |   |   |  |  |   |   |
|---|--|--|---|---|--|--|---|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>MODINAT ADEYEMO</b>   |  |   |   | 2. Date of Death<br>Month <b>8</b> Day <b>11</b> Year <b>96</b>  |  | 3. Time of Death<br><b>3:20pm</b>                                       |   |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>Holy CROSS HOSPITAL</b>   |  |   |   | 4b. City, Town, or Location of Death<br><b>SILVER SPRINGS</b>  |  | 4c. County of Death<br><b>MONTGOMERY</b>                                |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>NONE</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>Yrs.  | If Under 1 Year<br>Months <b>6</b> Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>8-5-96</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
|   | Usual Residence of Decedent  |  |   |   |  |  |   |   |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>  | 10b. County<br><b>AnneArundel</b>  | 10c. City, Town or Location<br><b>Laurel</b>  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |
|   | 10e. Street and Number<br><b>3447 Andrew Ct. #301</b>  |  |   |   | 10f. Zip Code<br><b>20724</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                             |   |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>0</b> College (1-4or 5+)   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>None</b>  |  |  | 16b. Kind of Business/Industry<br><b>None</b>                           |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>Mudashiru Adeyemo</b>  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Salamatu Tenga</b>   |  |   |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mudashiru Adeyemo</b>   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3447Andrew Ct.#301,Laurel,Md 20724</b>   |  |   |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Washington National</b>  |   | Date<br><b>8-14-96</b>   |  | 20c. Location - City or Town, State<br><b>Suitland,Md.</b>              |   |
|   | 21. Signature of Funeral Service Licensee<br>  |  |   |   | 22. Name and Address of Facility<br><b>Universal Mortuary Inc.<br/>411 Kennedy St., N.W. Washington, D.C.</b>  |  |   |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Cardio respiratory Failure</b><br>Due to (or as a consequence of):<br><b>b. grade IV IVH</b><br>Due to (or as a consequence of):<br><b>c. extreme prematurity</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |   |   |  |  |   |   |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |   |  |  |   |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.  |  |  |   |   |  |  |   |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)                                     |   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred                           |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D 43490</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>8/18/96</b>       |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br><b>Ernest L. Carter MD 9017 Alton Parkway Silver Spring MD 20910</b>  |  |  |   |   |  |  |   |   |
| 31. Date filed (Month, Day, Year)<br><b>AUG 15 1996</b>   |  |  |   | 32. Registrar's Signature<br>  |  |  |   |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25969

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John E. Bowie, Sr.

2. Date of Death

Month Day Year  
August 11, 1996

3. Time of Death

12:30 A.M.

4a. Facility Name (If not institution, give street and number)

Magnolia Center Nursing &amp; Rehabilitation

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

577-60-6039

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 8, 1906

9. Birthplace (State or Foreign Country)

Lowndes Co. Ala.

Usual Residence of Decedent

10e. State

District of Columbia

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

4640 Blaine Street, N. E.

10f. Zip Code

20019

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
Black15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Retired Photographer

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

John Ensley Bowie

18. Mother's Name (First, Middle, Maiden Summa)

Lavonia Caldwell

19a. Informant's Name/Relationship (Type, Print)

John E. Bowie, Jr. - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4640 Blaine Street, N. E., Washington, D. C. 20019

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Harmony Memorial Park

Date

8/19/96

20c. Location - City or Town, State

Landover, MD

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

STEWART FUNERAL HOME, Inc.  
4001 Benning Road, N. E., Washington, D. C.23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

Atherosclerotic Cardiovascular Disease

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Evacuation of subdural hematoma

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
Investigation6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

George C. Hawar, Jr., M.D.

29c. License number

034550

29d. Date signed (Month, Day, Year)

8-12-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George C. Hawar, Jr., M.D. 4850 Forbes Blvd. Lanham, Md. 20706

31. Date filed (Month, Day, Year)

AUG 16 1996

32. Registrar's Signature

John Andrew Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

John T. Donohue



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25970

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Elizabeth BENNETT

2. Date of Death

August 10 1996

3. Time of Death

2:45 p.m.

4a. Facility Name (If not institution, give street and number)

Doctors Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

132-05-0974

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 21, 1906

9. Birthplace (State or Foreign Country)

Jamaica, NY

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George

10c. City, Town or Location

Seabrook

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9410 Van Buren Street

10f. Zip Code

20706

10g. Citizen of What Country?

United States of America

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

George Smith

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Reilly

19a. Informant's Name/Relationship (Type, Print)

Monsignor Donald Bennett - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

St. Joseph's Catholic Church Garden City, New York

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mount St. Mary's Cemetery 8/16/96 Flushing, New York

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Steven S. Updell

22. Name and Address of Facility

Fairchild Sons Funeral Home

1201 Franklin Avenue Garden City, New York

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

SEPSIS

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE

ARTERIOVENOUS CARDIAC DYSFUNCTION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicidal 4 ☐ Homicidal

28a. Date of Injury (Month, Day Year)

N/A

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Paul A. DeVore MD

29c. License number

801852

29d. Date signed (Month, Day, Year)

August 10, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

PAUL A. DEVORE, MD 4203 QUONSBURY RD HYATTSVILLE MD 20781

31. Date filed (Month, Day, Year)

AUG 16 1996

32. Registrar's Signature

John Davidson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



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State of Maryland / Department of Health and Mental Hygiene

96 25971

## Certificate of Death

Reg. No.

|   |   |  |  |  |   |  |  |  |
|---|---|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Sara Leslie Brady   |  |  |  | 2. Date of Death<br>Month Day Year<br>August 2, 1996  |  | 3. Time of Death<br>5:47 AM  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>SHADY GROVE ADVENTIST HOSPITAL  |  |  |  | 4b. City, Town, or Location of Death<br>ROCKVILLE   |  | 4c. County of Death<br>MONTGOMERY  |  |
| Funeral<br>Director                           | 5. Social Security Number<br>No Number  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br>Yrs. | 8. Date of Birth (Month, Day, Year)<br>August 2, 1996   |  | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |
|   | Usual Residence of Decedent   |  |  |  | 10. Date of Death   |  | 11. Time of Death  |  |
| To Be Completed by Funeral Director           | 10a. State<br>Maryland  |  | 10b. County<br>Montgomery County   |  | 10c. City, Town or Location<br>Germantown   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|   | 10e. Street and Number<br>12900 McCubbin Lane   |  |  |  | 10f. Zip Code<br>20874  |  | 10g. Citizen of What Country?<br>United States of America  |  |
|   | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) None<br>College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Never Employed  |  | 16b. Kind of Business/Industry<br>None  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Mark Brady   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Barbara Smith  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Mark Brady - Father   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>12900 McCubbin Lane, Germantown, Maryland 20874  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metropolitan Crematory   |  | Date<br>8/7/96  |  | 20c. Location - City or Town, State<br>Alexandria, Virginia  |  |
|   | 21. Signature of Funeral Service Licensee M00690<br>David A. Carson   |  |  |  | 22. Name and Address of Facility<br>Metropolitan Funeral Service, Inc.<br>5517 Vine Street, Alexandria, Virginia 22310  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. Prematurity<br>Due to (or as a consequence of):<br>Severe pregnancy induced hypertension<br>Due to (or as a consequence of):<br>and<br>preterm labor<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |  |  |   |  |  |  |
|   | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Nephrotic syndrome (mother)  |  |  |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  |  |   |  |  |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28d. Describe how Injury occurred   |  |  |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
|   | 29b. Signature and title of certifier<br>D. Snyder  |  |  |  | 29c. License number<br>D38497   |  | 29d. Date signed (Month, Day, Year)<br>August 6, 1996  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Diane Snyder, M.D. 9715 Medical Center Drive Rockville, Maryland  |  |  |  |   |  |  |  |
|   | State<br>Registrar  | 31. Date filed (Month, Day, Year)<br>AUG 16 1996 |  |  |   | 32. Registrar's Signature<br>John A. ... |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene

96 25972

## Certificate of Death

Reg. No.

|   |  |   |   |  |  |   |  |  |
|---|--|---|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Patricia, Blake</b>   |   |   |  | 2. Date of Death<br>Month <b>08</b> Day <b>05</b> Year <b>96</b>   |   | 3. Time of Death<br><b>21:08</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Johns Hopkins Hospital</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |   | 4c. County of Death<br><b>Baltimore</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>212-54-1693</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>48</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>02-07-48</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Washington, D.C.</b>  |   | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>BALTIMORE</b>  |   | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 10e. Street and Number<br><b>7519 Ashton Valley W</b>   |  | 10f. Zip Code<br><b>21228</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> Collage (1-4 or 5+) <input checked="" type="checkbox"/> <b>4+</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>School Teacher</b>                |  | 16b. Kind of Business/Industry<br><b>Baltimore City Public Schools</b>   |   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Benson Blake, III</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Diggs</b>   |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Bencie M. Blake (Sister)</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6427 Woodgreen Circle Baltimore, Maryland 21207</b>                                      |   |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mount Olivet Cemetery</b>  |  | Date<br><b>8/10/96</b>   |   | 20c. Location - City or Town, State<br><b>Washington, D.C.</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br><b>B.C. Taylor</b>  |   |   |  | 22. Name and Address of Facility<br><b>Rotkins Funeral Home, Inc.<br/>4339 Hunt Place, N.E. Washington, D.C. 20019</b>   |   |  |  |
|   | 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>e. <b>Hepatic failure</b><br>Due to (or as a consequence of):<br>b. <b>Hepatitis B virus infection</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br><b>&lt; 6 mos.</b><br><b>&gt; 2 yrs</b> |   |   |  |  |   |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Massive gastrointestinal and nasal bleeding</b>   |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |  |  |   |  |  |
| 29b. Signature and title of certifier<br><b>Dr. Eldadah MD PhD</b>  |  |   |   | 29c. License number<br><b>NS104</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>08-05-70</b>                                      |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>ZAYD A. ELDADAH JOHNS HOPKINS HOSPITAL BALTO, MD 21205</b>   |  |   |   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 12, 1996</b>  |  | 32. Registrar's Signature<br><b>John H. H. H. H.</b>  |   |  |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

96 25973

## Certificate of Death

Reg. No.

|  |   |  |  |                                |  |
|--|---|--|--|--------------------------------|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>CHARLES BURT</b>   |  | 2. Date of Death<br>Month <b>AUG.</b> Day <b>07,</b> Year <b>1996</b>  |                                | 3. Time of Death<br><b>11:00AM</b>   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>6703 KILARNEY STREET</b>   |  | 4b. City, Town, or Location of Death<br><b>CLINTON</b>   |                                | 4c. County of Death<br><b>PRINCE GEORGES</b>   |
| Funeral<br>Director  | 5. Social Security Number<br><b>577-52-4743</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>58</b> Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|  | 8. Date of Birth (Month, Day, Year)<br><b>July 17, 1938</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Washington, D.C.</b>  |                                |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Prince George's</b>  |                                | 10c. City, Town or Location<br><b>Clinton</b>  |
|  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |                                |  |
|  | 10e. Street and Number<br><b>6703 Killarney Street</b>  |  | 10f. Zip Code  |                                | 10g. Citizen of What Country?<br><b>United States</b>  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>10/56-10/60</b> |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |  |                                |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Retired Supervisor in Refrigeration</b>              |                                | 16b. Kind of Business/Industry<br><b>Treasury Department</b>   |
|  | 17. Father's Name (First, Middle, Last)<br><b>Ralph H. Anderson</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ella Mae Burt</b>  |                                |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Thomas Harry Anderson - Brother</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7706 Vineyard Drive, Forestville, MD 20747</b>                   |                                |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Harmony Memorial Park</b>   |                                | 20c. Location - City or Town, State<br><b>Landover, MD</b>   |
|  | 21. Signature of Funeral Service Licensee<br><b>John T. Stewart III</b>   |  | 22. Name and Address of Facility<br><b>STEWART FUNERAL HOME, Inc.<br/>4001 Benning Road, N. E., Washington, D. C.</b>  |                                |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Arteriosclerotic Cardiovascular Disease</b>  |   |  |  |                                |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |   |  |  |                                |  |
| 24a. Was an autopsy performed?<br><b>INSPECTION</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |                                |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |  |                                |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |  |                                |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   |  |  |                                |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide  |   |  |  |                                |  |
| 28a. Date of Injury (Month, Day Year)  |   |  |  |                                |  |
| 28b. Time of injury<br>M   |   |  |  |                                |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |  |                                |  |
| 28d. Describe how injury occurred  |   |  |  |                                |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |  |                                |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |                                |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |  |                                |  |
| 29b. Signature and title of certifier<br><b>Theodore M. King, M.D.</b>   |   |  |  |                                |  |
| 29c. License number<br><b>O.C.M.E</b>  |   |  |  |                                |  |
| 29d. Date signed (Month, Day, Year)<br><b>AUG. 7, 1996</b>   |   |  |  |                                |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201</b>   |   |  |  |                                |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 12, 1996</b>   |   |  |  |                                |  |
| 32. Registrar's Signature<br><b>John D. ...</b>  |   |  |  |                                |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 25974  
Certificate of Death

Reg. No.

|   |  |   |  |   |   |   |  |  |   |    |   |                 |                                  |  |  |    |                              |                 |                                  |  |  |    |                             |  |                                  |  |  |    |   |                 |
|---|--|---|--|---|---|---|--|--|---|----|---|-----------------|----------------------------------|--|--|----|------------------------------|-----------------|----------------------------------|--|--|----|-----------------------------|--|----------------------------------|--|--|----|---|-----------------|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Sara Bahla</b>                                |   |  |   | 2. Date of Death<br>Month: <b>8</b> Day: <b>1</b> Year: <b>96</b> |   |  |  | 3. Time of Death<br><b>0615</b>                             |    |   |                 |                                  |  |  |    |                              |                 |                                  |  |  |    |                             |  |                                  |  |  |    |   |                 |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Holy Cross Hospital</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>      |   |  |  | 4c. County of Death<br><b>Montgomery</b>                    |    |   |                 |                                  |  |  |    |                              |                 |                                  |  |  |    |                             |  |                                  |  |  |    |   |                 |
| Funeral<br>Director   | 5. Social Security Number<br><b>577-066494</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>38</b> Yrs.                  |   | 8. Date of Birth (Month, Day, Year)<br><b>4/5/58</b> |  | 9. Birthplace (State or Foreign Country)<br><b>ETHIOPIA</b> |    |   |                 |                                  |  |  |    |                              |                 |                                  |  |  |    |                             |  |                                  |  |  |    |   |                 |
|   | Usual Residence of Decedent  |   |  |   |   |   |  |  |   |    |   |                 |                                  |  |  |    |                              |                 |                                  |  |  |    |                             |  |                                  |  |  |    |   |                 |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>PRINCE GEORGE</b>   |  | 10c. City, Town or Location<br><b>HYATTSVILLE</b>   |   |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |    |   |                 |                                  |  |  |    |                              |                 |                                  |  |  |    |                             |  |                                  |  |  |    |   |                 |
| 10e. Street and Number<br><b>1001 CHILLUM ROAD</b>  |  |   |  | 10f. Zip Code<br><b>22783</b>   |   |   |  | 10g. Citizen of What Country?<br><b>ETHIOPIA</b>   |   |    |   |                 |                                  |  |  |    |                              |                 |                                  |  |  |    |                             |  |                                  |  |  |    |   |                 |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                        |   |    |   |                 |                                  |  |  |    |                              |                 |                                  |  |  |    |                             |  |                                  |  |  |    |   |                 |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12TH</b> College (1-4 or 5+)  |  |   |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>ASSISTANT MANAGER</b>  |   |   |  | 16b. Kind of Business/Industry<br><b>SELLS COMPANY</b>   |   |    |   |                 |                                  |  |  |    |                              |                 |                                  |  |  |    |                             |  |                                  |  |  |    |   |                 |
| 17. Father's Name (First, Middle, Last)<br><b>ZAID TEKLEMARIAM</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>SARA BAHTA</b>  |   |   |  |  |   |    |   |                 |                                  |  |  |    |                              |                 |                                  |  |  |    |                             |  |                                  |  |  |    |   |                 |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>DANIEL BAHTA</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6511 VIRGINIA HILL AVE. ALEXANDRIA, VA 22510</b>  |   |   |  |  |   |    |   |                 |                                  |  |  |    |                              |                 |                                  |  |  |    |                             |  |                                  |  |  |    |   |                 |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GLENWOOD CEMETERY</b>  |   | Date<br><b>AUG/4/96</b>   |  | 20c. Location - City or Town, State<br><b>WASHINGTON, D.C.</b>                                 |   |    |   |                 |                                  |  |  |    |                              |                 |                                  |  |  |    |                             |  |                                  |  |  |    |   |                 |
| 21. Signature of Funeral Service Licensee<br> <b>276</b>  |  |   |  | 22. Name and Address of Facility<br><b>W.H. BACON FUNERAL HOME INC.</b><br><b>3447 14TH STREET, N.W. WASH, D.C. 20010</b>   |   |   |  |  |   |    |   |                 |                                  |  |  |    |                              |                 |                                  |  |  |    |                             |  |                                  |  |  |    |   |                 |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br><table border="0"> <tr> <td>a.</td> <td><b>Disseminated Intravascular Coagulation</b></td> <td><b>12 hours</b></td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td><b>Postpartum Hemorrhage</b></td> <td><b>16 hours</b></td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td><b>Large Fibroid Uterus</b></td> <td></td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td><b>Suspected Amniotic Fluid Embolus</b></td> <td><b>14 hours</b></td> </tr> </table> |  |   |  |   |   |   |  |  |   | a. | <b>Disseminated Intravascular Coagulation</b> | <b>12 hours</b> | Due to (or as a consequence of): |  |  | b. | <b>Postpartum Hemorrhage</b> | <b>16 hours</b> | Due to (or as a consequence of): |  |  | c. | <b>Large Fibroid Uterus</b> |  | Due to (or as a consequence of): |  |  | d. | <b>Suspected Amniotic Fluid Embolus</b> | <b>14 hours</b> |
| a.  | <b>Disseminated Intravascular Coagulation</b>  | <b>12 hours</b>   |  |   |   |   |  |  |   |    |   |                 |                                  |  |  |    |                              |                 |                                  |  |  |    |                             |  |                                  |  |  |    |   |                 |
| Due to (or as a consequence of):  |  |   |  |   |   |   |  |  |   |    |   |                 |                                  |  |  |    |                              |                 |                                  |  |  |    |                             |  |                                  |  |  |    |   |                 |
| b.  | <b>Postpartum Hemorrhage</b>   | <b>16 hours</b>   |  |   |   |   |  |  |   |    |   |                 |                                  |  |  |    |                              |                 |                                  |  |  |    |                             |  |                                  |  |  |    |   |                 |
| Due to (or as a consequence of):  |  |   |  |   |   |   |  |  |   |    |   |                 |                                  |  |  |    |                              |                 |                                  |  |  |    |                             |  |                                  |  |  |    |   |                 |
| c.  | <b>Large Fibroid Uterus</b>  |   |  |   |   |   |  |  |   |    |   |                 |                                  |  |  |    |                              |                 |                                  |  |  |    |                             |  |                                  |  |  |    |   |                 |
| Due to (or as a consequence of):  |  |   |  |   |   |   |  |  |   |    |   |                 |                                  |  |  |    |                              |                 |                                  |  |  |    |                             |  |                                  |  |  |    |   |                 |
| d.  | <b>Suspected Amniotic Fluid Embolus</b>  | <b>14 hours</b>   |  |   |   |   |  |  |   |    |   |                 |                                  |  |  |    |                              |                 |                                  |  |  |    |                             |  |                                  |  |  |    |   |                 |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Post Cesarean Section / Hysterectomy</b>   |  |   |  |   |   |   |  |  |   |    |   |                 |                                  |  |  |    |                              |                 |                                  |  |  |    |                             |  |                                  |  |  |    |   |                 |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |   |   |   |  |  |   |    |   |                 |                                  |  |  |    |                              |                 |                                  |  |  |    |                             |  |                                  |  |  |    |   |                 |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |  |   |    |   |                 |                                  |  |  |    |                              |                 |                                  |  |  |    |                             |  |                                  |  |  |    |   |                 |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |   |   |  |  |   |    |   |                 |                                  |  |  |    |                              |                 |                                  |  |  |    |                             |  |                                  |  |  |    |   |                 |
| 27. Manner of Death <b>As above</b><br><input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how Injury occurred  |   |    |   |                 |                                  |  |  |    |                              |                 |                                  |  |  |    |                             |  |                                  |  |  |    |   |                 |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |  |   |    |   |                 |                                  |  |  |    |                              |                 |                                  |  |  |    |                             |  |                                  |  |  |    |   |                 |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |   |   |   |  |  |   |    |   |                 |                                  |  |  |    |                              |                 |                                  |  |  |    |                             |  |                                  |  |  |    |   |                 |
| 29b. Signature and title of certifier<br> <b>MD</b>  |  |   |  | 29c. License number<br><b>037180</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>8/2/96</b>  |  |  |   |    |   |                 |                                  |  |  |    |                              |                 |                                  |  |  |    |                             |  |                                  |  |  |    |   |                 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Brad Norman MD 9801 Georgia Ave #224 SS, MD 20902</b>  |  |   |  |   |   |   |  |  |   |    |   |                 |                                  |  |  |    |                              |                 |                                  |  |  |    |                             |  |                                  |  |  |    |   |                 |
| 31. Date filed (Month, Day, Year)<br><b>AUG 14 1996</b>   |  | 32. Registrar's Signature<br>  |  |   |   |   |  |  |   |    |   |                 |                                  |  |  |    |                              |                 |                                  |  |  |    |                             |  |                                  |  |  |    |   |                 |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



96-4422-033

ITEM: 23 PART I, PER MEO FILM G-740 10/9/96 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

CMK

ITEMS: 23 PART I, 27, PER State of Maryland / Department of Health and Mental Hygiene

96 25975

MEO FILM G-739 9/6/96 t.t

## Certificate of Death

Reg. No.

|  |   |   |  |  |                                |  |   |
|--|---|---|--|--|--------------------------------|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>DWAYNE ANTHONY BELL</b>                        |   |  | 2. Date of Death<br>Month Day Year<br><b>AUGUST 06, 1996</b>   |                                | 3. Time of Death<br><b>1955PM</b>  |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>6409 PA. AVENUE #102</b> |   |  | 4b. City, Town, or Location of Death<br><b>FORESTVILLE</b>   |                                | 4c. County of Death<br><b>PRINCE GEORGES</b>   |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>220-88-5175</b>   |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>33</b> Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>NOV 7, 1962</b> |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                   |   |  |  |                                |  |   |
| Usual Residence of Decedent  |   |   |  |  |                                |  |   |
| 10a. State<br><b>MD</b>  |   | 10b. County<br><b>Prince Georges</b>  |  | 10c. City, Town or Location<br><b>Forestville</b>  |                                | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |
| 10e. Street and Number<br><b>6409 Pennsylvania Avenue</b>  |   |   |  | 10f. Zip Code<br><b>20747</b>  |                                | 10g. Citizen of What Country?<br><b>United States</b>  |   |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                            |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Custodian</b>  |                                | 16b. Kind of Business/Industry<br><b>Hospital</b>  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Rev. Mack McClean Bell</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Gloria Elizabeth Smith</b>   |                                |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Gloria E. Smith (mother)</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>117 Hoyle Lane, Serverna Park, Md. 21146</b>   |                                |  |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Harmony Memorial Park</b>  |  | Date<br><b>8/13/96</b>   |                                | 20c. Location - City or Town, State<br><b>LANDOVER, MARYLAND</b>                                   |   |
| 21. Signature of Funeral Service Licensee<br>  |   | 22. Name and Address of Facility<br><b>ALEXANDER S. POPE FUNERAL HOMES</b><br><b>5538 Marlboro Pike, Forestville, Md 20747</b>  |  |  |                                |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. CARDIAC HYPERTROPHY AND CORONARY ARTERY ATHEROSCLEROSIS</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |                                |  |   |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  |                                |  |   |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |   |   |  |  |                                |  |   |
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |                                |  |   |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |                                |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |   |
| 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |   |   |  | 28d. Describe how injury occurred  |                                |  |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |  |  |                                |  |   |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |   |  |  |                                |  |   |
| 29b. Signature and title of certifier<br>   |   |   |  | 29c. License number<br><b>O.C.M.E.</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>AUGUST 07, 1996</b>                                      |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201</b>   |   |   |  |  |                                |  |   |
| 31. Date filed (Month, Day, Year)<br><b>AUG 14, 1996</b>   |   | Registrar's Signature<br>  |  |  |                                |  |   |

3 1/2

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 25976

Reg. No.

|  |  |  |   |  |   |  |   |  |
|--|--|--|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner                | 1. Decedent's Name (First, Middle, Last)<br><b>WILLIAM BENNETT JR.</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>AUG. 11, 1996</b>  |  | 3. Time of Death<br><b>1330 PM</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>PRINCE GEORGES HOSPITAL CENTER</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>CHEVERLY</b>   |  | 4c. County of Death<br><b>PRINCE GEORGES</b>  |  |
| Funeral<br>Director                              | 5. Social Security Number<br><b>577-06-6460</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>18 Yrs.</b>  |  | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 10, 1977</b>   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Dist. Of Col.</b>   |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Pr. George's</b>  |  | 10c. City, Town or Location<br><b>Capitol Heights</b>   |  |
| To Be Completed by<br>Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>1523 Nova Avenue</b>   |  | 10f. Zip Code<br><b>20743</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |
| To Be Completed by<br>Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Student</b>   |  | 16b. Kind of Business/Industry<br><b>N/A</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>William Leroy Bennett, Sr.</b>  |  |
|  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Shelia Catherine Dawkins</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Shelia C. Dawkins/Mother</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1523 Nova Ave., Capitol Hghts., Md. 20743</b>   |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |
| To Be Completed by<br>Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Harmony Mem. Park</b>   |  | 20c. Location - City or Town, State<br><b>8/16/96 Hyattsville, Md.</b>  |  | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Jordan Funeral Service, Inc.<br/>4001 Benning Rd., N.E. (Wash., D.C. 20019)</b>  |  |
|  | 23a. Pert 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. Gunshot Wounds (2) of Head</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d.</b> |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| To Be Completed by<br>Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)<br><b>8/9/96</b>  |  |
|  | 28b. Time of Injury<br><b>0540 HX</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred<br><b>Subject shot</b>  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>120 Anacostia Avenue<br/>Washington, D.C. SE</b>   |  |
| State Registrar                                  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>O.C.M.E.</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>AUG. 12, 1996</b>   |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>THEODORE M. KING</b>  |  | 31. Date filed (Month, Day, Year)<br><b>AUG 14 1996</b>   |  | 32. Registrar's Signature<br>   |  | 33. Date of Death<br><b>11, 1996</b>  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

... ..

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State of Maryland / Department of Health and Mental Hygiene

96 25977

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William Lambert Beckwith, Jr.

2. Date of Death

August 14, 1996

Day Year

3. Time of Death

9:52

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

006-36-2371

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

56 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 29, 1939

9. Birthplace (State or Foreign Country)

Maine

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Smithsburg

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

31 West Walter Street

10f. Zip Code

21783

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 195913. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Medical Technologist

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

William Lambert Beckwith, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Louise Chandler Bishop

19a. Informant's Name/Relationship (Type, Print)

Suzanne S. Beckwith, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

31 West Walter Street, Smithsburg, Maryland 21783

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Rose Hill Cemetery

Date

8/17

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Douglas A. Fiery Funeral Home  
1331 Eastern Boulevard N., Hagerstown, MD 2174223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Pulmonary hemorrhage  
Due to (or as a consequence of):

Immediate

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Lung Cancer  
Due to (or as a consequence of):

4 months

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W.B. Kerns M.D. 22911 Jefferson Blvd. Smithsburg, Md.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

AUG 16 1996

John Andrew Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-d show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

96 25978

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |  |   |  |  |  |
|---|--|--|---|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>HERBERT BELL</b>  |  |   |  | 2. Date of Death<br>Month <b>August</b> Day <b>14</b> Year <b>1996</b>   |  |   |  | 3. Time of Death<br><b>10:30 AM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Salisbury Center/Genesis Eldercare</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Salisbury, MD</b>   |  |   |  | 4c. County of Death<br><b>Wicomico</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>231-42-8787</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>60</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>11-28-35</b>                                      |  | 9. Birthplace (State or Foreign Country)<br><b>VA</b>  |  |
|   | Usual Residence of Decedent  |  |   |  |  |  |   |  |  |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>VA</b>  |  | 10b. County<br><b>Accomack</b>  |  | 10c. City, Town or Location<br><b>New Church</b>   |  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|   | 10e. Street and Number   |  |   |  | 10f. Zip Code<br><b>23415</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Reconditioned automobiles</b>   |  |  |  | 16b. Kind of Business/Industry<br><b>car sales</b>  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>Samuel Bell</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Fannie M. Taylor</b>   |  |   |  |  |  |
|   | 19e. Informant's Name/Relationship (Type, Print)<br><b>Doris Hasty</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Stockton, MD</b>   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 20e. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Guilford Cemetery</b>  |  | Date<br><b>8-17-96</b>   |  | 20c. Location - City or Town, State<br><b>Bloxom, VA</b>                                    |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>James Y. Fox</i>   |  | 22. Name and Address of Facility<br><b>Fox Funeral Home, PO Box 278, Temperanceville, VA 23442</b>  |  |  |  |   |  |  |  |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. MASSIVE Pulmonary Hemorrhage</b><br>Due to (or as a consequence of):<br><b>b. Left upper lung CAVITARY lesion with</b><br>Due to (or as a consequence of):<br><b>c. Fungal AND Polymicrobial infection</b><br>Due to (or as a consequence of):<br><b>d. Left upper lung Cancer</b> |  |   |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>minutes</b><br><br><b>years</b>   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Advanced Emphysema</b>  |  |   |  |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |   |  |  |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28e. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |   |  |  |  |
|   | 29b. Signature and title of certifier<br><i>Michael R. Atkins</i>  |  |   |  | 29c. License number<br><b>DB9813</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>8/14/96</b>                                       |  |  |  |
| State Registrar                               | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Michael R. Atkins, M.D., 1104 Healthway Dr., Salisbury, MD 21804</b>  |  |   |  |  |  |   |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br><b>AUG 15 1996</b>  |  |   |  | 32. Registrar's Signature<br><i>John Davidson Radell</i>   |  |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

96 25979

## Certificate of Death

Reg. No.

|  |   |  |  |  |   |   |  |  |  |
|--|---|--|--|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Anna Mary Bogush                                  |  |  |  | 2. Date of Death<br>Month Day Year<br>August 18, 1996 |   | 3. Time of Death<br>3:22 p.m.                      |  |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br>Frederick Memorial Hospital |  |  |  | 4b. City, Town, or Location of Death<br>Frederick     |   | 4c. County of Death<br>Frederick                   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>178-01-2177  |  | 8. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br>76 Yrs.             |   | 6. Data of Birth (Month, Day, Year)<br>Jul 3, 1920 |  |  |
|  | 9. Birthplace (State or Foreign Country)<br>Pennsylvania                                      |  | 10a. State<br>Penna.   |  | 10b. County<br>Schuylkill                             |   | 10c. City, Town or Location<br>Saint Clair         |  |  |
| Usual Residence of Decedent  |   |  |  |  |   |   |  |  |  |
| 10a. State<br>Penna.   |   |  | 10b. County<br>Schuylkill  |  |   | 10c. City, Town or Location<br>Saint Clair  |  |  |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  | 10e. Street and Number<br>27 North Price Street  |  |   | 10f. Zip Code<br>17970  |  |  |  |
| 10g. Citizen of What Country?<br>U.S.A.  |   |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |  |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10 Collage (1-4or 5+) 10                               |  |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Garment Production  |   |  | 16b. Kind of Business/Industry<br>Factory  |  |   | 17. Father's Name (First, Middle, Last)<br>George KOVACH  |  |  |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary FATULA   |   |  | 19a. Informant's Name/Relationship (Type, Print)<br>Mr. Walter J. Bogush/Husband   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>27 N Price Street, Saint Clair, Pennsylvania 17970   |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Ft Indiantown Gap Cemtry Aug 21, 1996  |  |   | 20c. Location - City or Town, State<br>Annville, PA Ft. Indiantown Gap,   |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Robert M0706</i>   |   |  | 22. Name and Address of Facility<br>Keeney & Basford P.A. Funeral Home<br>106 East Church Street, Frederick, MD 21701  |  |   |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><u>CONGESTIVE HEART FAILURE</u><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br><br>Approximate Interval Between Onset and Death<br><u>6 hrs</u> |   |  |  |  |   |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>INSULIN DEPENDENT DIABETES MELLITUS</u>   |   |  |  |  |   |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |   |  |  |  |   |   |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |  |  |   |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |  |  |   |   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |  |  |   |   |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |   |  |  |  |   |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   |  | 28a. Date of Injury (Month, Day Year)  |  |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 28d. Describe how injury occurred  |   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |  |  |  |   |   |  |  |  |
| 29b. Signature and title of certifier<br><i>Neil Warandek MD</i>   |   |  | 29c. License number<br>D47611  |  |   | 29d. Date signed (Month, Day, Year)<br>8/18/96  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>NEIL WARANDEK MD 1475 TATNEY AVE., #204 FREDERICK, MD 21702.   |   |  |  |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>AUG 19 1996   |   |  | 32. Registrar's Signature<br><i>John Anderson Randall</i>  |  |   |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



96 25980

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Georgia Belle Barrett</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>August</b> DAY <b>14</b> , YEAR <b>1996</b>   |  | 3. TIME OF DEATH<br><b>0200</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>241-07-9957</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>83</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>March 12, 1913</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>North Carolina</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Laurelwood Nursing Center</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Elkton</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Cecil</b>   |  |  |  | 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Cecil</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Elkton</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>110 Frenchtown Road</b>   |  |
| 10f. ZIP CODE<br><b>21921</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>  |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>n/a</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Robert Shumate</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Sue Leona Bell</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Belva Pulice</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>110 Frenchtown Road - Elkton, MD 21921</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Gilpin Manor Memorial Park 8-16 1996</b>   |  |  |  |
| 20c. LOCATION — City or Town, State<br><b>Elkton, Maryland</b>  |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Donald S. Hicks</b>  |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>Hicks Home for Funerals, P.A.<br/>103 W. Stockton St., Elkton, MD 21921-5521</b>   |  |  |  | 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>End Stage Parkinson Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Dehydration &amp; Under Nutrition</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Aspiration</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Approximate Interval Between Onset and Death<br><b>10 years</b><br><b>6 mths</b><br><b>2 days</b> |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Arteriosclerotic Heart Disease</b>   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>8-16-1996</b>   |  |  |  |
| 28b. TIME OF INJURY<br><b>M</b>   |  |  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>At home</b>  |  |  |  | 28e. DESCRIBE HOW INJURY OCCURRED<br><b>Aspiration</b>   |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>Elkton, Maryland</b>   |  |  |  | 29. CERTIFIER<br>(Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Jayantilal K. Patel, M.D.</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>22307</b>  |  |  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>8/16/96</b>   |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Jayantilal K. Patel, M.D. - 123 Singerly Avenue - Elkton, MD 21921</b>   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 16 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 25981

|   |   |   |   |  |  |   |  |  |   |    |                     |  |    |           |        |    |                                       |  |    |  |
|---|---|---|---|--|--|---|--|--|---|----|---------------------|--|----|-----------|--------|----|---------------------------------------|--|----|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Grace L. Beutenmuller   |   |   |  | 2. Date of Death<br>Month Day Year<br>August 17 1996   |   | 3. Time of Death<br>0600   |  |   |    |                     |  |    |           |        |    |                                       |  |    |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Union Hospital  |   |   |  | 4b. City, Town, or Location of Death<br>Elkton   |   | 4c. County of Death<br>Cecil                                     |  |   |    |                     |  |    |           |        |    |                                       |  |    |  |
| Funeral<br>Director   | 5. Social Security Number<br>072-12-5622  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>82 Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br>Oct. 15, 1913             |  |   |    |                     |  |    |           |        |    |                                       |  |    |  |
|   | 9. Birthplace (State or Foreign Country)<br>New York  |   | 10a. State<br>Md.   |  | 10b. County<br>Cecil   |   | 10c. City, Town or Location<br>Elkton                            |  |   |    |                     |  |    |           |        |    |                                       |  |    |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |   |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |  |   |    |                     |  |    |           |        |    |                                       |  |    |  |
|   | 10e. Street and Number<br>2 Woods Road, Glen Farms  |   |   |  | 10f. Zip Code<br>21921   |   | 10g. Citizen of What Country?<br>U.S.A.                          |  |   |    |                     |  |    |           |        |    |                                       |  |    |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |   |    |                     |  |    |           |        |    |                                       |  |    |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Secretary                                |  | 16b. Kind of Business/Industry<br>Cecil County Health Dept.  |   |  |  |   |    |                     |  |    |           |        |    |                                       |  |    |  |
|   | 17. Father's Name (First, Middle, Last)<br>George Thomas Salt   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Georgia Vannostrand   |   |  |  |   |    |                     |  |    |           |        |    |                                       |  |    |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Ruth B. Huff, daughter  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1316 Livingstone Rd., York, Pa. 17404   |   |  |  |   |    |                     |  |    |           |        |    |                                       |  |    |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>R. A. Ferris & Co. 8/20/96  |  | 20c. Location - City or Town, State<br>West Chester, Pa.   |   |  |  |   |    |                     |  |    |           |        |    |                                       |  |    |  |
|   | 21. Signature of Funeral Service Licensee   |   |   |  | 22. Name and Address of Facility<br>259 E. Main St.,<br>Gee Funeral Home Elkton, Md. 21921   |   |  |  |   |    |                     |  |    |           |        |    |                                       |  |    |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |  |  |   |  |  |   |    |                     |  |    |           |        |    |                                       |  |    |  |
|   | <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td>Respiratory Failure</td> <td>Approximate interval Between Onset and Death<br/>4-5 days</td> </tr> <tr> <td>b.</td> <td>Pneumonia</td> <td>5 days</td> </tr> <tr> <td>c.</td> <td>Chronic obstructive Pulmonary disease</td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> |   |   |  |  |   |  |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Respiratory Failure | Approximate interval Between Onset and Death<br>4-5 days | b. | Pneumonia | 5 days | c. | Chronic obstructive Pulmonary disease |  | d. |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | a.  | Respiratory Failure   | Approximate interval Between Onset and Death<br>4-5 days  |  |  |   |  |  |   |    |                     |  |    |           |        |    |                                       |  |    |  |
|   | b.  | Pneumonia   | 5 days  |  |  |   |  |  |   |    |                     |  |    |           |        |    |                                       |  |    |  |
|   | c.  | Chronic obstructive Pulmonary disease   |   |  |  |   |  |  |   |    |                     |  |    |           |        |    |                                       |  |    |  |
|   | d.  |   |   |  |  |   |  |  |   |    |                     |  |    |           |        |    |                                       |  |    |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |   |    |                     |  |    |           |        |    |                                       |  |    |  |
|   |   |   |   |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |    |                     |  |    |           |        |    |                                       |  |    |  |
|   |   |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |   |    |                     |  |    |           |        |    |                                       |  |    |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 28. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |   |  |  |   |  |  |   |    |                     |  |    |           |        |    |                                       |  |    |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M                 |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |   |    |                     |  |    |           |        |    |                                       |  |    |  |
|   |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28d. Describe how injury occurred        |  |   |  |  |   |    |                     |  |    |           |        |    |                                       |  |    |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br>[Signature] M.D.   |   | 29c. License number<br>D44102            |  | 29d. Date signed (Month, Day, Year)<br>8/20/96  |  |  |   |    |                     |  |    |           |        |    |                                       |  |    |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>William Renzulli M.D. 901 Warburton Rd Elkton, Md 21921   |   |   |   |  |  |   |  |  |   |    |                     |  |    |           |        |    |                                       |  |    |  |
| 31. Date filed (Month, Day, Year)<br>AUG 20 1996  |   |   |   | 32. Registrar's Signature<br>[Signature] |  |   |  |  |   |    |                     |  |    |           |        |    |                                       |  |    |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar





96 25982

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>HILDA F. CROSS</i>   |  |  |  | 2. DATE OF DEATH<br>MONTH <i>AUGUST</i> DAY <i>11</i> YEAR <i>1996</i>   |  | 3. TIME OF DEATH<br><i>10:10 A M</i>   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>216-44-2624</i>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>94</i> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>SEPT. 17, 1901</i>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>PENNSYLVANIA</i>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>NATIONAL LUTHERAN HOME</i>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>ROCKVILLE</i>  |  |
| 9c. COUNTY OF DEATH<br><i>MONTGOMERY</i>  |  |  |  | 10a. STATE<br><i>MD.</i>   |  | 10b. COUNTY<br><i>MONTGOMERY</i>   |  |
| 10c. CITY, TOWN OR LOCATION<br><i>GAITHERSBURG</i>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><i>3 HIGHLAND AVENUE</i>   |  |
| 10f. ZIP CODE<br><i>20877</i>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>WHITE</i>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>8</i> College (1-4 or 5+) <i></i>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>FEDERAL EMPLOYEE</i>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>U.S. GOVT.</i>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>WILLIAM C. FORESTER</i>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>SARAH DUGAN</i>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>REV. DR. REICHARD</i>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>9701- VEIRS DR., ROCKVILLE, MD. 20850</i>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>PARKLAWN CEMETERY 8/15</i>   |  | 20c. LOCATION — City or Town, State<br><i>ROCKVILLE, MD.</i>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>W. M. Hyman</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>HYSONG CO., INC.<br/>1300- N ST., R.W., WASH., DC</i>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <i>Urosepsis</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>Cachexia</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <i>multi infarct dementia</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <i>Alzheimer's Disease</i><br>Approximate interval Between Onset and Death<br><i>24 hours</i><br><i>12 months</i><br><i>10 years</i><br><i>20 years</i> |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Hypothyroidism, Coronary Artery Disease, Pernicious Anemia</i><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><i>M</i>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Schemm M. D.</i>  |  |  |  | 29c. LICENSE NUMBER<br><i>D13668</i>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>August 12, 1996</i>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>DR. CHRISTOPHER SCHEMM - 9701-VEIRS DR, ROCKVILLE, MD</i>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><i>AUG 14 1996</i>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Johi Hunter-Rodell</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25983

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Annette Harrison Chaney

2. Date of Death

Month August Day 7 Year 1996

3. Time of Death

9:00 P.M.

4a. Facility Name (If not institution, give street and number)

12320 Whitehall Drive

4b. City, Town, or Location of Death

Bowie

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

212 66 4416

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

80

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 23 1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Mitchellville

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

15501 Hall Rd.

10f. Zip Code

20721

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Gail Borden Harrison

18. Mother's Name (First, Middle, Maiden Surname)

Pearl Edith Chaney

19a. Informant's Name/Relationship (Type, Print)

Rodney G. Chaney Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12320 Whitehall Drive Bowie Maryland 20715

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Barnabas Church Cemetery 8/10/96 Maryland

Date

20c. Location - City or Town, State

Upper Marlboro

21. Signature of Funeral Service Licensee

Robert E. Evans Pres.

22. Name and Address of Facility

Robert E. Evans Funeral Home, P.A.

16000 Annapolis Rd. Bowie Maryland 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

hepatic insufficiency

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

metastatic adenocarcinoma in liver

Due to (or as a consequence of):

5 weeks

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Martin D. Wertz

29c. License number

D23743

29d. Date signed (Month, Day, Year)

8/9/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARTIN D WERTZ 7525 Greenway Ct On Greenbelt Maryland 21044

31. Date filed (Month, Day, Year)

AUG 14 1996

32. Registrar's Signature

Jill D. ...

State Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25984

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Elsie Josephine CUNNINGHAM</b>   |  |  |  | 2. Date of Death<br>Month Day Year<br><b>Aug. 16 1996</b>   |  | 3. Time of Death<br><b>4:41 A.M.</b>   |  |
| 4a. Facility Name (If not Institution, give street and number)<br><b>Colton Villa Nursing Center</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Hagerstown</b>   |  | 4c. County of Death<br><b>Washington</b>   |  |
| 5. Social Security Number<br><b>219-12-0317</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>89</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 20 1906</b>   |  |
| 9. Birthplace (State or Foreign Country)<br><b>North Dakota</b>   |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Washington</b>  |  | 10c. City, Town or Location<br><b>Hagerstown</b>   |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>11 W. Baltimore Street</b>  |  | 10f. Zip Code<br><b>21740</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b><br>College (1-4 or 5+) <b>0</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>  |  | 16b. Kind of Business/Industry<br><b>Her own home</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Carl Nylander</b>  |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anna Christine Johnson</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Robert L. Cunningham /Son</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11574 Bemisderfer Road Greencastle, Pa. 17225</b>   |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                      |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Tabor Cemetery Aug. 19, 1996</b>   |  | 20c. Location - City or Town, State<br><b>Fairview, Maryland</b>   |  | 21. Signature of Funeral Service Licensee<br><i>Scott M. Minnich</i>  |  | 22. Name and Address of Facility<br><b>Minnich Funeral Home</b><br><b>415 E. Wilson Blvd. Hagerstown, Maryland 21740</b>   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Arteriosclerotic cardiovascular disease</b><br>Due to (or as a consequence of):<br>b. <b>Congestive heart failure</b><br>Due to (or as a consequence of):<br>c. <b>Possible pulmonary embolism</b><br>Due to (or as a consequence of):<br>d. <b>Coronary artery disease</b> |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Right hip Fracture</b><br><b>Osteoporosis</b>  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  |
| 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><i>Jerry V. Coppes M.D.</i>   |  |
| 29c. License number<br><b>D41131</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>8/16/96</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JERRY V. COPPES 750 Dual Hwy. Hagerstown MD 20740</b>  |  | 31. Date filed (Month, Day, Year)<br><b>AUG 19 1996</b>  |  |
| 32. Registrar's Signature<br><i>Jahia Anderson-Rodell</i>   |  |  |  |   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25985

## Certificate of Death

Reg. No.

|   |  |   |  |  |  |  |   |  |
|---|--|---|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><u>Ronald Edwin Daum</u>   |   |  |  | 2. Date of Death<br>Month <u>August</u> Day <u>8</u> Year <u>1996</u>  |  | 3. Time of Death<br><u>6:50 AM</u>                                      |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><u>Washington Adventist Hospital</u>   |   |  |  | 4b. City, Town, or Location of Death<br><u>Takoma Park</u>   |  | 4c. County of Death<br><u>Montgomery</u>                                |  |
| Funeral<br>Director   | 5. Social Security Number<br><u>217-30-7082</u>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><u>61</u> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><u>December 8, 1934</u>          |  |
|   | 9. Birthplace (State or Foreign Country)<br><u>South Dakota</u>  |   | 10a. State<br><u>Maryland</u>  |  | 10b. County<br><u>Prince George's</u>  |  | 10c. City, Town or Location<br><u>Hyattsville</u>                       |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 10e. Street and Number<br><u>2721 Nicholson Street</u>   |  | 10f. Zip Code<br><u>20782</u>  |  | 10g. Citizen of What Country?<br><u>USA</u>                             |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>College</u>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Shipping &amp; Receiving Clerk</u> |  | 16b. Kind of Business/Industry<br><u>Electronics</u>   |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><u>Edward Andrew Daum</u>   |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Dorothea Louise Forster</u>  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><u>R. Scott Daum ( Son )</u>   |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>19009 906 Fetter's Mill Road, Bryn Athyn, Pennsylvania</u>                                  |  |   |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Metropolitan Funeral Ser.</u>   |  | 20c. Date<br><u>8/10/96</u>  |  | 20d. Location - City or Town, State<br><u>Alexandria, Va.</u>           |  |
|   | 21. Signature of Funeral Service Licensee<br><u>[Signature]</u>  |   |  |  | 22. Name and Address of Facility <u>Francis Gasch's Sons Funeral Home</u><br><u>4739 Baltimore Avenue, Hyattsville, Md. 20781</u>  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><u>a. Respiratory failure</u><br>Due to (or as a consequence of):<br><u>b. Sepsis</u><br>Due to (or as a consequence of):<br><u>c. Myotonic Dystrophy</u><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><u>d.</u> |   |  |  |  |  |   |  |
|   | 23b. Approximate Interval Between Onset and Death<br><u>2 Days</u>   |   |  |  |  |  |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |  |  |  |   |  |
| 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |  |  |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><u>M</u>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
| 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |  |  |  |   |  |
| 29b. Signature and title of certifier<br><u>[Signature]</u>   |  | 29c. License number<br><u>D45560</u>  |  | 29d. Date signed (Month, Day, Year)<br><u>8-9-96</u>                         |  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>3000 Mitchellville Rd, Bowie MD 20716</u>  |  |   |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><u>AUG 14 1996</u>   |  | 32. Registrar's Signature<br><u>[Signature]</u>   |  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

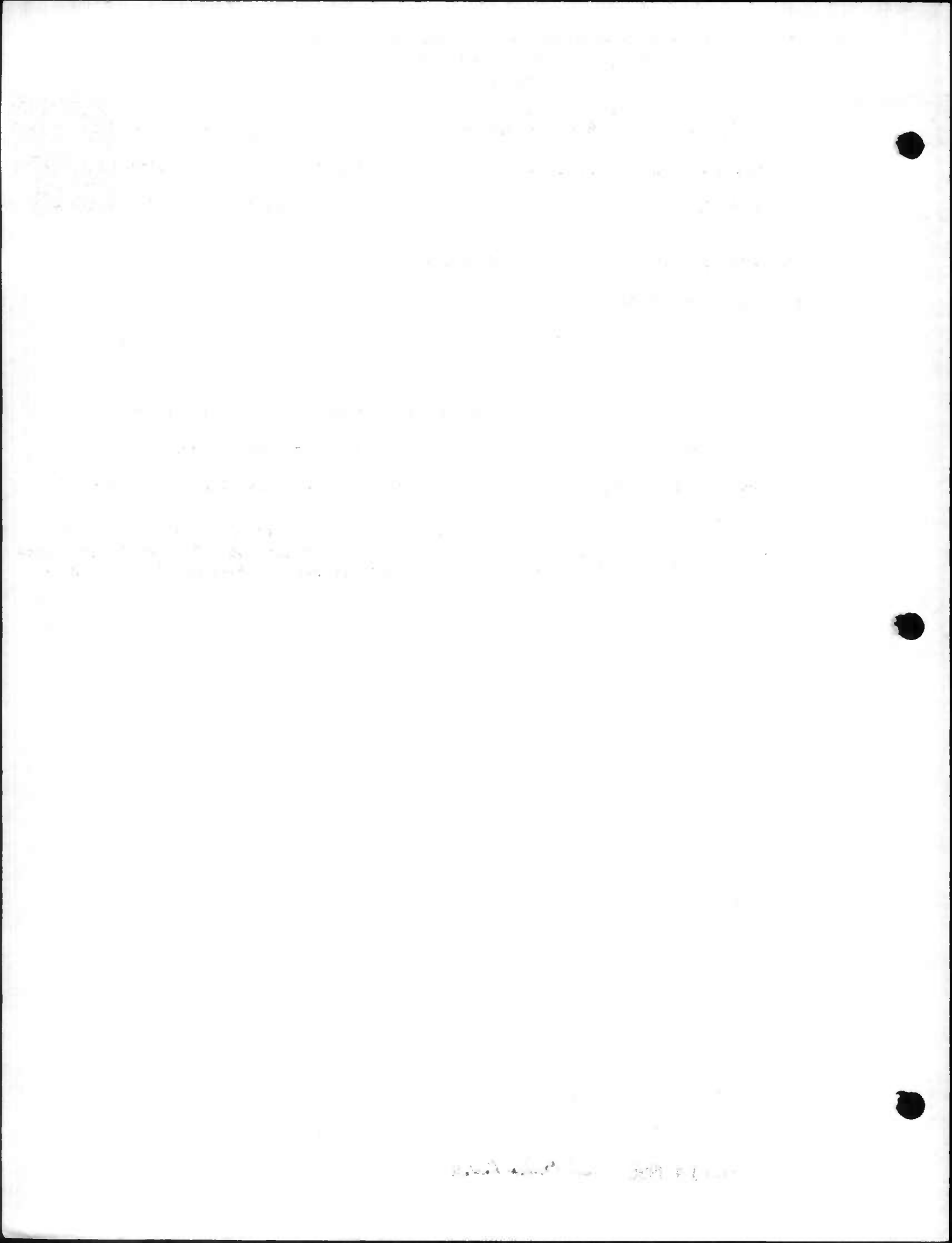
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





96 25986

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>LILLIAN LOIS EMERICK  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>August 21, 1996   |  | 3. TIME OF DEATH<br>9:45 PM   |  |
| 4. SOCIAL SECURITY NUMBER<br>214-07-3797  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>77 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Apr. 23, 1919   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Pennsylvania  |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Washington County Hospital  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Hagerstown   |  |
| 9c. COUNTY OF DEATH<br>Washington   |  |   |  | 10a. STATE<br>Md.   |  | 10b. COUNTY<br>Washington   |  |
| 10c. CITY, TOWN OR LOCATION<br>Hagerstown   |  |   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |
| 10e. STREET AND NUMBER<br>6 Cypress St. Apt 1   |  |   |  | 10f. ZIP CODE<br>21742  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (14 or 5+) 12  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Home  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Roy V. Coughenour  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Dora Harden  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Carole E. Pledger   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>535 Innsbruck Ave. Great Falls, Va. 22066  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Smithsburg Cemetery August 25, 1996  |  | 20c. LOCATION — City or Town, State<br>Smithsburg, Md.  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>James L. Davis</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Davis Funeral Home 12525 Bradbury Ave.<br>Smithsburg, Md. 21783   |  |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Major Trauma<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |   | Approximate Interval Between Onset and Death<br>30 mins.   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)<br>August 21, 1996   |  | 28b. TIME OF INJURY<br>8:40 AM  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED<br>car hit tractor trailer  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>RT 40   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>Westbound RT 40 Hagerstown  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Edward W. Ditto, III</i>  |  |   |  | 29c. LICENSE NUMBER<br>D01062   |  | 29d. DATE SIGNED (Month, Day, Year)<br>August 23, 1996  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Edward W. Ditto, III, M.D. 217 W. Washington St. Hagerstown, MD 21740  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>AUG 26 1996  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>John H. Randall</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

25987

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES FOSTER

2. Date of Death

Month August Day 11, Year 1996

3. Time of Death

9:00 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

251-21-6282

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

37

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 11, 1959

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Beltsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11916 Beltsville Drive

10f. Zip Code

20705

10g. Citizen of What Country?

United States of America

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
Black15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Landscaper

16b. Kind of Business/Industry

Landscaping Industry

17. Father's Name (First, Middle, Last)

George Williams

18. Mother's Name (First, Middle, Maiden Surname)

Barbara Foster

19a. Informant's Name/Relationship (Type, Print)

Barbara Williams - Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

104 Morman Street Seneca, South Carolina 29678

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Oak Grove Cemetery

Date

8-16-96

20c. Location - City or Town, State

Seneca, South Carolina

21. Signature of Funeral Service Licensee

Steven S. Woodall

22. Name and Address of Facility

Adams Mortuary

300 N. Walnut Street Seneca, South Carolina

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

Several months

Acquired Immune deficiency Syndrome Several years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

History of Tuberculosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

MK Karim MD

29c. License number

D-18895

29d. Date signed (Month, Day, Year)

August 11, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOBARAK KARIM, 7610 CARROLL AVENUE, TAKOMA PARK, MD 20912

31. Date filed (Month, Day, Year)

AUG 16 1996

Registrar's Signature

John H. Hurdall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25988

Amended # 10a. P.G.C. 8-12-96 CR

## Certificate of Death

Reg. No.

|                                     |   |  |  |  |   |  |  |  |   |  |
|-------------------------------------|---|--|--|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>John Fenwick</b>   |  |  |  | 2. Date of Death<br>Month <b>08</b> Day <b>08</b> Year <b>96</b>  |  |  |  | 3. Time of Death<br><b>1230 pm</b>  |  |
|                                     | 4a. Facility Name (If not institution, give street and number)<br><b>Sutton Hill Manor</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore, MD</b>  |  |  |  | 4c. County of Death   |  |
| Funeral<br>Director                 | 5. Social Security Number<br><b>577328522</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>67</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>11/19/28</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Wash., D.C.</b>  |  |
|                                     | Usual Residence of Decedent   |  |  |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>MD</b>                               |  | 10c. City, Town or Location<br><b>Washington, DC</b>  |  |
| To Be Completed by Funeral Director | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  | 10e. Street and Number<br><b>1353 Emerald St., NE</b>   |  |  |  | 10f. Zip Code<br><b>20002</b>   |  |
|                                     | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  |
|                                     | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  |
|                                     | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Driver</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>PUT. INDUSTRY</b>  |  |  |  | 17. Father's Name (First, Middle, Last)<br><b>James A. Fenwick</b>  |  |
|                                     | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Susie A. Myles</b>  |  |  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Opal Fenwick /Wife</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1353 Emerald St., NE Washington, DC 20002</b>   |  |
|                                     | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Harmony Memorial Park</b>  |  |  |  | 20c. Location - City or Town, State<br><b>Landover, MD</b>  |  |
|                                     | 21. Signature of Funeral Service Licensee<br><b>Tyrone J. Young</b>   |  |  |  | 22. Name and Address of Facility<br><b>Tyrone J. Young Funeral Services<br/>5635 Eads St., NE Wash., DC 20019</b>   |  |  |  | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>AIDS</b><br>Due to (or as a consequence of):<br><b>PNEUMONIA</b><br>Due to (or as a consequence of):<br><b>ANAEMIA</b> |  |
|                                     | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
|                                     | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  |
|                                     | 28a. Date of Injury (Month, Day, Year)  |  |  |  | 28b. Time of Injury<br><b>M</b>   |  |  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 28d. Describe how injury occurred   |   |  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |  |
| Physician<br>/Medical<br>Examiner   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |  | 29b. Signature and title of certifier<br><b>[Signature]</b> (MD)  |  |  |  | 29c. License number<br><b>D31414</b>  |  |
|                                     | 29d. Date signed (Month, Day, Year)<br><b>8/8/96</b>  |  |  |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>SHOALIE A. HASHMI, 821 N. EUTAW ST SUITE 308, Baltimore MD 21201</b>   |  |  |  | 31. Date filed (Month, Day, Year)<br><b>AUG 12 1996</b>   |  |
|                                     | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |  | 33. Registrar's Title<br><b>[Title]</b>   |  |  |  | 34. Registrar's Office<br><b>[Office]</b>   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

96 25989

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Pauline L. Fry

2. Date of Death

August 10, 1996

3. Time of Death

12:45 A.M.

4a. Facility Name (If not institution, give street and number)

114 Cree Drive

4b. City, Town, or Location of Death

Forest Heights

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

150-28-1608

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 23, 1921

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Forest Heights

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

114 Cree Drive

10f. Zip Code

20745

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Registered Nurse

16b. Kind of Business/Industry

Nursing

17. Father's Name (First, Middle, Last)

John Williams

18. Mother's Name (First, Middle, Maiden Surname)

Pauline Rebecca Hipple

19a. Informant's Name/Relationship (Type, Print)

Paula L. Valentino/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

114 Cree Drive, Forest Heights, Md. 20745

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 8/11/96

Date

20c. Location - City or Town, State

Alexandria, Va.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

George P. Kalas Funeral Home  
6160 Oxon Hill Rd. Oxon Hill, Md. 20745

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Carcinoma

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 months

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Lung Carcinoma

Due to (or as a consequence of):

1 year

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Destructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D 16410

29d. Date signed (Month, Day, Year)

8/12/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Gabriel Jaffe, M.D. 7500 Hanover Parkway, #105, Greenbelt, Md. 20770

31. Date filed (Month, Day, Year)

AUG 12, 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25990

## Certificate of Death

Reg. No.

|  |   |   |  |  |  |  |  |  |
|--|---|---|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Frances Beam FISHER</b>                              |   |  |  | 2. Date of Death<br>Month <u>August</u> Day <u>19</u> Year <u>1996</u> |  | 3. Time of Death<br><u>7:53</u>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Washington County Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Hagerstown</b>              |  | 4c. County of Death<br><b>Washington</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>217-28-6264</b>   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>June 15, 1927</b>  | 9. Birthplace (State or Foreign Country)<br><b>Kentucky</b>                          |
|  | Usual Residence of Decedent   |   |  |  |  |  |  |  |
| 10a. State<br><b>MD</b>  |   | 10b. County<br><b>Washington</b>  |  | 10c. City, Town or Location<br><b>Hagerstown</b>   |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>16901 Harbinger Court</b>   |   |   |  | 10f. Zip Code<br><b>21740</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>0</b>   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>cutter and basket weaver</b>   |  | 16b. Kind of Business/Industry<br><b>leather</b>   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Green Spurlock</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elsie Ledford</b>  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Earl J. Fisher, Jr.</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>16901 Harbinger Ct., Hagerstown, Md. 21740</b>   |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Olivet Cemetery</b>  |  | Data<br><b>8-22-96</b>   |  | 20c. Location - City or Town, State<br><b>Frederick, Maryland</b>  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Scott M. Minnich</i>   |   |   |  | 22. Name and Address of Facility<br><b>MINNICH FUNERAL HOME</b><br><b>415 E. Wilson Blvd., Hagerstown, Md. 21740</b>   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <u>Respiratory Failure</u><br>Due to (or as a consequence of):<br><br>b. <u>Chronic Obstructive Pulmonary Disease</u><br>Due to (or as a consequence of):<br><br>c. _____<br>Due to (or as a consequence of):<br><br>d. _____<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |   |   |  |  |  |  |  | Approximate Interval Between Onset and Death<br><br><u>hrs</u><br><br><u>3 years</u> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |
|  |   |   |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |
|  |   |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |
|  |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |   |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br><i>W.B. Kerns MD</i>  |   |   |  | 29c. License number<br><b>D38977</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>8/21/96</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>W.B. Kerns, M. D.</b><br><b>22911 Jefferson Blvd Sh. Hagerstown MD</b>  |   |   |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 21 1996</b>  |   | 32. Registrar's Signature<br><i>John Andrew Parker</i>  |  |  |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MELVIN ARCHABALD FLAUGHTER</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>August 16, 1996</b>  |  | 3. TIME OF DEATH<br><b>9:09pm</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-24-6066</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 8. AGE (In yrs. last birthday)<br><b>68</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>May 12, 1928</b>                                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>16531-B Sabillasville RD</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Sabillasville</b>   |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>Frederick</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Sabillasville</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>16531-B Sabillasville RD</b>  |  |  |  | 10f. ZIP CODE<br><b>21780</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>II</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>8</b>   |  | 15b. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>General Maintenance</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Government Installation</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Arch Flaughter</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Edna Forrest</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Alice I. Flaughter</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>16531-B Sabillasville RD, Sabillasville, MD 21780</b>                                       |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Brown's Cemetery</b>   |  | DATE<br><b>8/20</b>   |  | 20c. LOCATION — City or Town, State<br><b>Foxville, MD</b>                                      |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>James A. Bowersox</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Grove Funeral Home, Inc.<br/>50 S Broad St Waynesboro PA 17268</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. <b>lung cancer</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  | b. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
|  |  | c. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
|  |  | d. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
|  |  | Approximate interval Between Onset and Death<br><b>10 months</b>   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Hind Hamdan, MD</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>DH6473</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>August 19, 1996</b>                                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Hind Hamdan 363 S. Cleveland Ave Ste 201 Hagerstown MD 21740</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 19 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Johi Anderson-Barlett</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 25992

Reg. No.

|  |   |                             |   |  |  |  |   |  |   |  |
|--|---|-----------------------------|---|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last) <b>Mildred Elaine Felty</b>                    |                             |   |  |  |  | 2. Date of Death<br>Month Day Year<br><b>August 17, 1996</b>                                |  | 3. Time of Death<br><b>12:42pm</b>                          |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>543 Wilson Rd.</b> |                             |   |  |  |  | 4b. City, Town, or Location of Death<br><b>Rising Sun</b>                                   |  | 4c. County of Death<br><b>Cecil</b>                         |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>213-38-9770</b>   |                             | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>57</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Dec 31 1938</b>                                   |  | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b> |  |
|  | Usual Residence of Decedent   |                             |   |  |  |  |   |  |   |  |
| 10a. State<br><b>MD</b>  |   | 10b. County<br><b>Cecil</b> |   | 10c. City, Town or Location<br><b>Rising Sun</b>   |  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |
| 10e. Street and Number<br><b>543 Wilson Rd.</b>  |   |                             |   | 10f. Zip Code<br><b>21911</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   |                             | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>2</b>   |   |                             |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Food Service</b> |  |  | 16b. Kind of Business/Industry<br><b>Board of Education</b>                                 |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Ernest Brammer</b>   |   |                             |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Burnette</b>  |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>E. Garrett Felty, Sr.</b>   |   |                             |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>543 Wilson Rd. Rising Sun MD 21911</b> |   |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |                             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Brookview Cemetery Aug 21 1996</b>   |  |  | 20c. Location - City or Town, State<br><b>Rising Sun MD</b>  |   |  |   |  |
| 21. Signature of Funeral Service Licensee<br><i>Richard L. Joodie</i>  |   |                             |   |  |  | 22. Name and Address of Facility<br><b>R. T. Foard Funeral Home, P.A.<br/>111 S Queen St. Rising Sun MD 21911</b>                          |   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>ASEVD</b> <i>Cardiopulmonary Arrest</i><br>Due to (or as a consequence of):<br><b>ASEVD</b><br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |                             |   |  |  |  |   |  |   | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>N/A</i>   |   |                             |   |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |
|  |   |                             |   |  |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
|  |   |                             |   |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |                             | 28. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   |                             | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how Injury occurred                           |  |
|  |   |                             | 28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |                             | 29b. Signature and title of certifier<br><i>Dr. [Signature]</i>   |  |  | 29c. License number<br><b>023984</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>8/17/96</b>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>106 Bow St Union Hospital Elkton, Md</b>  |   |                             |   |  |  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 19 1996</b>  |   |                             | 32. Registrar's Signature<br><i>Gulie Davidson-Rendell</i>  |  |  |  |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

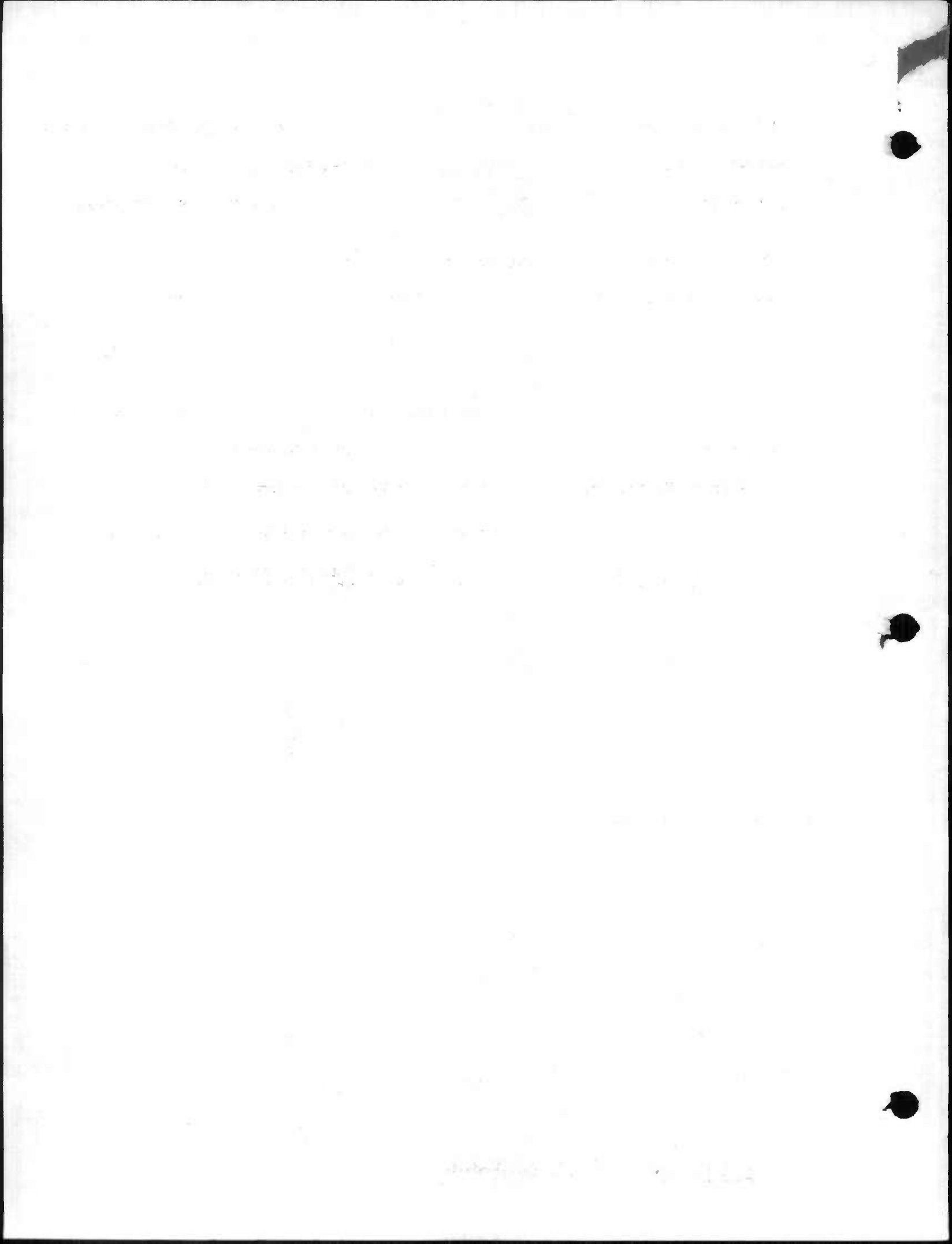
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



ITEMS-10a, 10b, 10c, 10e, 10f, PER  
INFORMANT FILM 6-744 2/3/97 tt

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25993

|   |   |  |   |                                |  |  |  |   |  |  |
|---|---|--|---|--------------------------------|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><u>Mozell Frazier</u><br><u>Frazier</u>   |  | 2. Date of Death<br>Month Day Year<br>08 10 1996  |                                | 3. Time of Death<br><u>5:20 PM</u>   |  |  |   |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><u>11602 Clairton Ct.</u>   |  | 4b. City, Town, or Location of Death<br><u>Mitchellville</u>  |                                | 4c. County of Death<br><u>Prince George's</u>  |  |  |   |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><u>201-12-0288</u>   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><u>87</u> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |  |  |   |  |  |
|   | 8. Date of Birth (Month, Day, Year)<br><u>02-03-1909</u>  |  | 9. Birthplace (State or Foreign Country)<br><u>Greenwood, SC</u>  |                                |  |  |  |   |  |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent<br>10a. State<br><u>PENNSYLVANIA</u>  |  | 10b. County<br><u>Prince George's</u>   |                                | 10c. City, Town or Location<br><u>Mitchellville</u> PHILADELPHIA   |  |  |   |  |  |
|   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |                                |  |  |  |   |  |  |
|   | 10e. Street and Number<br><u>11602 Clairton Ct.</u>   |  | 10f. Zip Code<br><u>20721</u>   |                                | 10g. Citizen of What Country?<br><u>USA</u>  |  |  |   |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  |   |  |  |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>Black</u>   |  |   |                                |  |  |  |   |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>10</u> College (1-4or 5+) <u></u>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Sealer (canning)</u>                  |                                | 16b. Kind of Business/Industry<br><u>Crown-Corking &amp; Seals</u>   |  |  |   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><u>Charles Moragne</u>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Malinda Wells</u>   |                                |  |  |  |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><u>Yvonne M. Coon/Niece</u>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>11602 Clairton Ct. Mitchellville, MD 20721</u>    |                                |  |  |  |   |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Mount Peace</u>  |                                | 20c. Location - City or Town, State<br><u>08/15/96 Philadelphia, PA</u>  |  |  |   |  |  |
|   | 21. Signature of Funeral Service Licensee<br><u>Edward K. Brown</u>   |  | 22. Name and Address of Facility<br><u>Tyrone J. Young Funeral Services</u><br><u>5635 Eads Street, NE Washington, DC 20019</u>                       |                                |  |  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |  |   |                                |  |  |  |   |  |  |
| <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <u>Cardiopulmonary arrest</u><br/>Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b. <u>widespread vaginal cancer</u><br/>Due to (or as a consequence of):</td> </tr> <tr> <td>c. <u></u><br/>Due to (or as a consequence of):</td> </tr> <tr> <td>d. <u></u><br/>Due to (or as a consequence of):</td> </tr> </table> |   |  |   |                                | Immediate Cause (Final disease or condition resulting in death)  | a. <u>Cardiopulmonary arrest</u><br>Due to (or as a consequence of): | Approximate Interval Between Onset and Death | b. <u>widespread vaginal cancer</u><br>Due to (or as a consequence of): | c. <u></u><br>Due to (or as a consequence of): | d. <u></u><br>Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death)   | a. <u>Cardiopulmonary arrest</u><br>Due to (or as a consequence of):  | Approximate Interval Between Onset and Death                                   |   |                                |  |  |  |   |  |  |
|   | b. <u>widespread vaginal cancer</u><br>Due to (or as a consequence of):   |  |   |                                |  |  |  |   |  |  |
|   | c. <u></u><br>Due to (or as a consequence of):  |  |   |                                |  |  |  |   |  |  |
|   | d. <u></u><br>Due to (or as a consequence of):  |  |   |                                |  |  |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |   |                                |  |  |  |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |  |   |                                |  |  |  |   |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   |                                |  |  |  |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |   |                                |  |  |  |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   |                                |  |  |  |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |   |  |   |                                |  |  |  |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   |  |   |                                |  |  |  |   |  |  |
| 28a. Date of Injury (Month, Day Year)   |   |  |   |                                |  |  |  |   |  |  |
| 28b. Time of Injury<br><u>M</u>   |   |  |   |                                |  |  |  |   |  |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |   |                                |  |  |  |   |  |  |
| 28d. Describe how injury occurred   |   |  |   |                                |  |  |  |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |   |                                |  |  |  |   |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |                                |  |  |  |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |  |   |                                |  |  |  |   |  |  |
| 29b. Signature and title of certifier<br><u>Dr. Jehan El-Bayoumi MD</u>   |   |  |   |                                |  |  |  |   |  |  |
| 29c. License number<br><u>DC 16360</u>  |   |  |   |                                |  |  |  |   |  |  |
| 29d. Date signed (Month, Day, Year)<br><u>8/12/96</u>   |   |  |   |                                |  |  |  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>Dr. Jehan El-Bayoumi 260 Pennsylvania Ave NW Wash. DC 20037</u>  |   |  |   |                                |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><u>AUG 13 1996</u>   |   |  |   |                                |  |  |  |   |  |  |
| 32. Registrar Signature<br><u>John Shuckman-Randall</u>   |   |  |   |                                |  |  |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





96 25994

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ETHEL A. GREIF</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>August</b> DAY <b>5</b> YEAR <b>1996</b>  |  | 3. TIME OF DEATH<br><b>11:21 P.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-14-3452</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>78</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>SEPT. 18, 1917</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>NATIONAL LUTHERAN HOME</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>ROCKVILLE</b>  |  |
| 9c. COUNTY OF DEATH<br><b>MARYLAND-MONTGOMERY</b>  |  |  |  | 10a. STATE<br><b>MD.</b>   |  | 10b. COUNTY<br><b>BALTIMORE CITY</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>1439- RIVERSIDE AVENUE</b>  |  |
| 10f. ZIP CODE<br><b>21230</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>CLERK</b>  |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>CLERK</b>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>U.S.F. &amp; G</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>WILLIAM HUNTER</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MYRTLE BRAECKLINE</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>REV. DR. REICHARD</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9701- VEIRS DRIVE, ROCKVILLE, MD. 20850</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>METROPOLITAN CREMATORY-8/6 ALEXANDRIA, VA.</b>   |  |  |  |
| 20c. LOCATION — City or Town, State  |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>W. M. Hysong</b>   |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>HYSONG CO., INC.<br/>1300-N STREET, NW, WASH., DC</b>   |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Bladder Carcinoma, Metastatic</b><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |
| 24. Approximate interval Between Onset and Death<br><b>years</b>   |  |  |  | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> Other (Specify)<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  |  |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE NOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Daniel A. Jaffer, MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D33138</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>August 6, 1996</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Daniel A. Jaffer, MD 12850 Middlebrook Rd Germantown</b>   |  |  |  | 31. DATE FILED (Month, Day, Year)<br><b>AUG 14 1996</b>  |  |  |  |
| 32. REGISTRAR'S SIGNATURE<br><b>J. A. [Signature]</b>  |  |  |  |  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25995

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Pamela

2. Date of Death

Month Day Year

August 9, 1996

3. Time of Death

3:30 AM

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince Georges

5. Social Security Number

578-72-3646

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

41

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

April 30, 1955

9. Birthplace (State or Foreign Country)

Washington D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Fort Washington

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

9407 Dashia Drive

10f. Zip Code

20744

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

private

17. Father's Name (First, Middle, Last)

Donald Carter

18. Mother's Name (First, Middle, Maiden Surname)

Monica Brown

19a. Informant's Name/Relationship (Type, Print)

Michael Ginyard /husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9407 Dashia Dr. Fort Washington, MD 20744

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metropolitan Crematory

Date

Aug. 14

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

Kimberly C. Buscoe-Tonic

22. Name and Address of Facility

MARSHALL'S FUNERAL HOME  
4308 SUITLAND ROAD SUITLAND, MD 2074623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Gastrointestinal Bleeding

Due to (or as a consequence of):

b. Hepatic failure

Due to (or as a consequence of):

c. Kidney failure

Due to (or as a consequence of):

d. + sepsis

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending  
Investigation 6 ☐ Could not be  
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Michael Sidorous M.D.

29c. License number

D 45365

29d. Date signed (Month, Day, Year)

8-9-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Sidorous M.D. 11701 Livingston Rd. #101

31. Date filed (Month, Day, Year)

AUG 14, 1996

32. Registrar's Signature

John M. ...

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

(3)

1. The first part of the paper discusses the general theory of the subject, and the second part discusses the special case of the subject.

2. The first part of the paper discusses the general theory of the subject, and the second part discusses the special case of the subject.

3. The first part of the paper discusses the general theory of the subject, and the second part discusses the special case of the subject.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25996

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |   |  |   |   |  |   |  |
|---|---|--|---|--|--|---|--|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Charles Alex Graham   |  |   |  |  | 2. Date of Death<br>Month Day Year<br>August 10, 1996   |  | 3. Time of Death<br>8:10 P.M.                   |   |  |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>12502 Kingsfield Lane   |  |   |  |  | 4b. City, Town, or Location of Death<br>Bowie   |  | 4c. County of Death<br>Prince George's          |   |  |   |  |
| Funeral<br>Director   | 5. Social Security Number<br>579 42 9446  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>62 Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br>Nov. 27, 1933             |   | 9. Birthplace (State or Foreign Country)<br>West Virginia |  |   |  |
|   | Usual Residence of Decedent   |  |   |  |  | 10a. State<br>Maryland  |  | 10b. County<br>Prince George's                  |   | 10c. City, Town or Location<br>Bowie   |   |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |  | 10e. Street and Number<br>12502 Kingsfield Lane   |  | 10f. Zip Code<br>20715                          |   | 10g. Citizen of What Country?<br>United States                                       |   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 54-55 |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White |   |   |  |   |  |
| To Be Completed by Physician/Medical Examiner   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+)  |  |   |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Assistant Drafting Engineer  |  | 16b. Kind of Business/Industry<br>Bell Atlantic |   |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br>Charles Graham   |  |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Myrtle Myers   |  |   |   |  |   |  |
| CR  | 19a. Informant's Name/Relationship (Type, Print)<br>Brenda Grubb-Graham Wife  |  |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>12502 Kingsfield Lane Bowie Maryland 20715   |  |   |   |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Oakland Cemetery 8/14/96  |  |   |   |  | 20c. Location - City or Town, State<br>Oakland Maryland   |  |
| Physician<br>/Medical<br>Examiner   | 21. Signature of Funeral Service Licensee<br>Robert E. Evans Pres   |  |   |  |  | 22. Name and Address of Facility<br>Robert E. Evans Funeral Home, P.A.<br>16000 Annapolis Rd. Bowie Maryland 20715  |  |   |   |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. hepatic failure<br>Due to (or as a consequence of):<br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. metastatic cancer of colon<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d. |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |   |  | Approximate interval between Onset and Death<br>4 weeks<br>15 mos   |  |
| Division of Vital Records, P.O. Box 68760,  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |  | 26. Place of Death (Check only one)<br>Hospitals: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |   |  |   |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |   |  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M                        |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |
|   | 28d. Describe how injury occurred   |  |   |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner  | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  | 29b. Signature and title of certifier<br>Martin O. Weitz  |  |   |   |  | 29c. License number<br>D23743   |  |
|   | 29d. Date signed (Month, Day, Year)<br>D23743   |  |   |  |  |   |  |   |   |  |   |  |
| State<br>Registrar  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>MARTIN D. WEITZ 7525 Greenway Ct A Greenbelt MD 20770   |  |   |  |  | 31. Date filed (Month, Day, Year)<br>AUG 14 1996  |  |   |   |  | 32. Registrar's Signature<br>John Anderson-Randall  |  |



Certificate of Death

Reg. No.

|  |  |   |   |  |  |  |   |  |   |   |   |                                     |                                     |                                     |
|--|--|---|---|--|--|--|---|--|---|---|---|-------------------------------------|-------------------------------------|-------------------------------------|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Marion Snyder Goudy</b>   |   |   |  | 2. Date of Death<br>Month Day Year<br><b>August 17, 1996</b>   |  | 3. Time of Death<br><b>1:50 pm</b>                                      |  |   |   |   |                                     |                                     |                                     |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Laurelwood Nursing Center</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>Elkton</b>  |  | 4c. County of Death<br><b>Cecil</b>                                     |  |   |   |   |                                     |                                     |                                     |
| Funeral<br>Director  | 5. Social Security Number<br><b>199-07-1732</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>April 28 1916</b>             |  |   |   |   |                                     |                                     |                                     |
|  | 9. Birthplace (State or Foreign Country)<br><b>Penna.</b>  |   | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Cecil</b>  |  | 10c. City, Town or Location<br><b>Earleville</b>                        |  |   |   |   |                                     |                                     |                                     |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br><b>24 Snug Harbor Way</b>   |  | 10f. Zip Code<br><b>21919</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |  |   |   |   |                                     |                                     |                                     |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b> |  |   |   |   |                                     |                                     |                                     |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+) <b>College</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                     |  | 16b. Kind of Business/Industry<br><b>Home</b>  |  |   |  |   |   |   |                                     |                                     |                                     |
|  | 17. Father's Name (First, Middle, Last)<br><b>Penrose L. Snyder</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Kate C. Esterline</b>  |  |   |  |   |   |   |                                     |                                     |                                     |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Charles R. Goudy (son)</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>24 Snug Harbor Way Earleville, MD. 21919</b>   |  |   |  |   |   |   |                                     |                                     |                                     |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gracelawn Mem Pk.</b>  |  | 20c. Location - City or Town, State<br><b>8/21/96 New Castle, DE.</b>  |  |   |  |   |   |   |                                     |                                     |                                     |
|  | 21. Signature of Funeral Service Licensee<br> <b>MO0510</b>  |   |   |  | 22. Name and Address of Facility<br><b>Galena Funeral Home of Stephen Schaech</b><br><b>Box 235 Galena, MD. 21635</b>  |  |   |  |   |   |   |                                     |                                     |                                     |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |  |  |  |   |  |   |   |   |                                     |                                     |                                     |
|  | <table border="1"> <tr> <td rowspan="4">                 Immediate Cause (Final disease or condition resulting in death)<br/><br/>                 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last             </td> <td>a. <b>Fractured right hip</b><br/>Due to (or as a consequence of):</td> <td rowspan="4">                 Approximate interval between Onset and Death<br/><br/> <b>2 months</b> </td> </tr> <tr> <td>b. Due to (or as a consequence of):</td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> </tr> </table> |   |   |  |  |  |   |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <b>Fractured right hip</b><br>Due to (or as a consequence of): | Approximate interval between Onset and Death<br><br><b>2 months</b> | b. Due to (or as a consequence of): | c. Due to (or as a consequence of): | d. Due to (or as a consequence of): |
|  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | a. <b>Fractured right hip</b><br>Due to (or as a consequence of): | Approximate interval between Onset and Death<br><br><b>2 months</b>   |  |  |  |   |  |   |   |   |                                     |                                     |                                     |
| b. Due to (or as a consequence of):  |  |   |   |  |  |  |   |  |   |   |   |                                     |                                     |                                     |
| c. Due to (or as a consequence of):  |  |   |   |  |  |  |   |  |   |   |   |                                     |                                     |                                     |
| d. Due to (or as a consequence of):  |  |   |   |  |  |  |   |  |   |   |   |                                     |                                     |                                     |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Severe CAD with previous CABG with Chronic Cararone Rx.</b><br><b>Recent CVA with aphasia, and Parkinsonism.</b>  |  |   |   |  |  |  |   |  |   |   |   |                                     |                                     |                                     |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |   |  |  |  |   |  |   |   |   |                                     |                                     |                                     |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |  |  |  |   |  |   |   |   |                                     |                                     |                                     |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |   |  |  |  |   |  |   |   |   |                                     |                                     |                                     |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |  |  |  |   |  |   |   |   |                                     |                                     |                                     |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |   |  |  |  |   |  |   |   |   |                                     |                                     |                                     |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  |   |   |  |  |  |   |  |   |   |   |                                     |                                     |                                     |
| 28a. Date of Injury (Month, Day Year)<br><b>JUNE 30, 1996</b>  |  |   |   |  |  |  |   |  |   |   |   |                                     |                                     |                                     |
| 28b. Time of Injury<br><b>11:50</b>  |  |   |   |  |  |  |   |  |   |   |   |                                     |                                     |                                     |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |  |  |  |   |  |   |   |   |                                     |                                     |                                     |
| 28d. Describe how injury occurred<br><b>SUBJECT SLIPPED AND FELL</b>   |  |   |   |  |  |  |   |  |   |   |   |                                     |                                     |                                     |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>NURSING HOME</b>  |  |   |   |  |  |  |   |  |   |   |   |                                     |                                     |                                     |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>LAURELWOOD NURSING CENTER CECIL CO., MD.</b>  |  |   |   |  |  |  |   |  |   |   |   |                                     |                                     |                                     |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |  |  |  |   |  |   |   |   |                                     |                                     |                                     |
| 29b. Signature and title of certifier<br>   |  |   |   |  |  |  |   |  |   |   |   |                                     |                                     |                                     |
| 29c. License number<br><b>D 07129</b>  |  |   |   |  |  |  |   |  |   |   |   |                                     |                                     |                                     |
| 29d. Date signed (Month, Day, Year)<br><b>August 18, 1996</b>  |  |   |   |  |  |  |   |  |   |   |   |                                     |                                     |                                     |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Wallace Obenshain Box 415 Cecilton, MD. 21913</b>   |  |   |   |  |  |  |   |  |   |   |   |                                     |                                     |                                     |
| 31. Date filed (Month, Day, Year)<br><b>AUG 19 1996</b>  |  |   |   |  |  |  |   |  |   |   |   |                                     |                                     |                                     |
| 32. Registrar's Signature<br>   |  |   |   |  |  |  |   |  |   |   |   |                                     |                                     |                                     |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 25998

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RACHEL S. HOUSE

2. Date of Death

Month Day Year  
August 13, 1996

3. Time of Death

12:25 P.M.

4a. Facility Name (If not institution, give street and number)

MEDBRIDGE MEDICAL &amp; PHYSICAL REHABILITATION

4b. City, Town, or Location of Death

Wheaton

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

577-60-7210

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 5, 1917

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

10b. County

District of Columbia

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

503 24th Street, N. E.

10f. Zip Code

20002

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Retired Clerk

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Edward Savoy

18. Mother's Name (First, Middle, Maiden Surname)

Nettie Diamond

19a. Informant's Name/Relationship (Type, Print)

Donald R. Wines - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4528 C Street, S. E., Washington, D.C. 20019

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lincoln Memorial Cemetery

Date

8/19/96

20c. Location - City or Town, State

Suitland, MD

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

STEWART FUNERAL HOME, INC.

4001 Benning Road, N.E., Washington, D. C.

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Carcinoma of the Tongue

10 Months

Due to (or as a consequence of):

b. Carcinoma of the Neck

12 Months

Due to (or as a consequence of):

c. Carcinoma of the Esophagus

36 Months

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending Investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John T. Stewart III

29c. License number

D44120

29d. Date signed (Month, Day, Year)

August 14, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Takao L. Sato, M.D., 9715 Medical Center Drive, Rockville, Maryland, 20850

31. Date filed (Month, Day, Year)

AUG 16 1996

32. Registrar's Signature

John D. ...

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

THE UNIVERSITY OF CHICAGO  
LIBRARY  
1000 S. MICHIGAN AVE.  
CHICAGO, ILL. 60607

UNIVERSITY OF CHICAGO  
LIBRARY  
1000 S. MICHIGAN AVE.  
CHICAGO, ILL. 60607

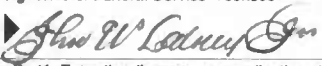

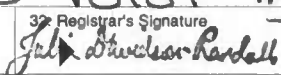
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 25999

## Certificate of Death

Reg. No.

|  |   |   |   |  |   |  |  |                                     |   |
|--|---|---|---|--|---|--|--|-------------------------------------|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><u>George Jay Harris Sr.</u>                                      |   |   |  |   | 2. Date of Death<br>Month <u>August</u> Day <u>2</u> Year <u>1996</u>  |  | 3. Time of Death<br><u>10 55 AM</u> |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><u>Johns Hopkins Bayview Medical Center</u> |   |   |  |   | 4b. City, Town, or Location of Death<br><u>Baltimore</u>   |  | 4c. County of Death<br><u>n/a</u>   |   |
| Funeral<br>Director  | 5. Social Security Number<br><u>237-72-4116</u>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><u>50</u> Yrs.   | If Under 1 Year<br>Months <u>  </u> Days <u>  </u>  | If Under 24 Hrs.<br>Hours <u>  </u> Min. <u>  </u>   | 8. Date of Birth (Month, Day, Year)<br><u>January 13, 1946</u>                                 |                                     | 9. Birthplace (State or Foreign Country)<br><u>North Carolina</u> |
|  | Usual Residence of Decedent   |   |   |  |   |  |  |                                     |   |
| 10a. State<br><u>Maryland</u>  |   | 10b. County<br><u>Prince Georges</u>  |   | 10c. City, Town or Location<br><u>Fort Washington</u>  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                     |   |
| 10e. Street and Number<br><u>8917 Rusland Court</u>  |   |   |   | 10f. Zip Code<br><u>20744</u>  |   | 10g. Citizen of What Country?<br><u>United States</u>  |  |                                     |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <u>  </u> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <u>  </u> |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>Black</u>                        |                                     |   |
| 15. Decedent's Education (Specify only highest grade completed)<br><u>Elementary/Secondary (0-12) 12th grade</u>   |   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Taxi Cab Driver</u>  |   |  | 16b. Kind of Business/Industry<br><u>Self-Employed</u>   |                                     |   |
| 17. Father's Name (First, Middle, Last)<br><u>Jennis Harris</u>  |   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Ethel Ree Wooten</u>  |  |  |                                     |   |
| 19a. Informant's Name/Relationship (Type, Print) (daughter)<br><u>Jennifer R. Harris Gaynor</u>  |   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>3914 Noyes Circle, Apt. 4; Randallstown, Maryland 21133</u> |  |  |                                     |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <u>  </u>  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>St. John's Missionary Baptist Church Cemetery</u>  |  |   | 20c. Location - City or Town, State<br><u>Aug. 10, 1996; Falkland, North Carolina</u>  |  |                                     |   |
| 21. Signature of Funeral Service Licensee<br>  |   |   |   |  | 22. Name and Address of Facility<br><u>Latney's Funeral Home, Inc.</u><br><u>3831 Georgia Avenue, N.W.; Washington, D.C. 20011</u>                              |  |  |                                     |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |   |  |   |  |  |                                     |   |
| a. <u>Dissecting Aortic Aneurysm 2 hrs.</u><br>Due to (or as a consequence of): <u>  </u>  |   |   |   |  |   |  |  |                                     |   |
| b. <u>  </u><br>Due to (or as a consequence of): <u>  </u>   |   |   |   |  |   |  |  |                                     |   |
| c. <u>  </u><br>Due to (or as a consequence of): <u>  </u>   |   |   |   |  |   |  |  |                                     |   |
| d. <u>  </u><br>Due to (or as a consequence of): <u>  </u>   |   |   |   |  |   |  |  |                                     |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>  </u>  |   |   |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |                                     |   |
|  |   |   |   |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                                     |   |
|  |   |   |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                                     |   |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <u>  </u> |  |   |  |  |                                     |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |   |   | 28a. Date of Injury (Month, Day Year)<br><u>  </u>  |  | 28b. Time of Injury<br><u>  </u> M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |                                     |   |
|  |   |   | 28d. Describe how Injury occurred<br><u>  </u>  |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><u>  </u>  |  |                                     |   |
|  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><u>  </u>   |  |   |  |  |                                     |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                          |   |   |   |  |   |  |  |                                     |   |
| 29b. Signature and title of certifier<br>   |   |   |   |  | 29c. License number<br><u>MD D-11455 Exp 8/97</u>   |  | 29d. Date signed (Month, Day, Year)<br><u>August 5, 1996</u>                                   |                                     |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>GUSTAV C VOIGT MD</u>   |   |   |   |  | 31. Date filed (Month, Day, Year)<br><u>AUG 13 1996</u>   |  |  |                                     |   |
| 32. Registrar's Signature<br>   |   |   |   |  | 33. Registrar's Name<br><u>John A. Randall</u>  |  |  |                                     |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 26000

Amended # 8. P.G.C. 8-14-96 CR

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

PAMELA R. HENDRICKS

2. Date of Death

Month Day Year  
AUGUST 11, 1996

3. Time of Death

6:30PM

4a. Facility Name (If not institution, give street and number)

PRINCE GEORGE'S GENERAL HOSPITAL

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

PRINCE GEORGE'S

5. Social Security Number

578-88-6421

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

35 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) 61  
JAN. 7, 1996

9. Birthplace (State or Foreign Country)

WASHINGTON, DC

Usual Residence of Decedent

10a. State  
MARYLAND10b. County  
PRINCE GEORGE'S

10c. City, Town or Location

LANDOVER

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1843 RYDERWOOD

COURT

10f. Zip Code

20785

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

NURSE ASSISTANT

16b. Kind of Business/Industry

PVT./NURSING HOME

17. Father's Name (First, Middle, Last)

JOHN K. HOLMES

18. Mother's Name (First, Middle, Maiden Surname)

JENNIE L. HENDRICKS

19a. Informant's Name/Relationship (Type, Print)

JENNIE PETERSON/ MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1435 E. ST. NE WASHINGTON, DC 20002

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

HARMONY MEMORIAL PARK

8-16-96

LANDOVER, MARYLAND

21. Signature of Funeral Service Licensee

Suawana L. Braxton

22. Name and Address of Facility

MARSHALL'S FUNERAL HOME

4217 NINTH ST. NW WASHINGTON, DC 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. SEPTIC SHOCK, PNEUMONIA

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

48 HRS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Alcoholic hepatitis + cirrhosis

Due to (or as a consequence of):

&gt;5 YRS

c. Alcoholic Cardiomyopathy

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28d. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28e. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Linda D Green MD

29c. License number

D 21428

29d. Date signed (Month, Day, Year)

Aug 12, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LINDA D GREEN MD

PG HOSPITAL

31. Date filed (Month, Day, Year)

AUG 14 1996

32. Registrar's Signature

John Anderson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3

